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BUILDING BUREAUCRACY AND INVADING PATIENT PRIVACY: MARYLAND'S HEALTH CARE REGULATIONS

DALE SNYDER

Maryland is a microcosm of the serious problems besetting the health care system in the United States. Health care in Maryland is a $15 billion industry in which doctors and patients are losing control and the number of uninsured persons is rising. The state's health care policy—an incoherent bundle of regulations and contradictions—is driving up the cost of health care while artificially trying to hammer down prices. In 1996 alone, the cost of a hospital stay increased almost twice as fast as the national average. Yet, by mid-February 1998, legislators had introduced 85 new health care and companion bills and 18 mental health bills in the state's General Assembly.

Politics, not patient choice, has been the driving force behind the growth of Maryland's health care system. The health care behemoth grew rapidly after the enactment of the Health Care and Insurance Reform Act, an 81-page, last-minute bill pushed through in 1993 at the height of the national debate on the failed Clinton Health Security Act. One legislator aptly described it as the "Clinton Plan in miniature." As a result, Maryland's system now features:

- No fewer than five regulatory bureaucracies to control health care delivery at a cost of over $30 million a year.
- A government-run health care database that violates a patient's right to privacy. In Big Brother fashion, sensitive information on every visit to doctors and hospitals is entered without a patient's consent. Ironically, Marylanders can protect the confidentiality of their driving records, but not that of their medical records, in the state's computerized data banks.
- More mandates on the health insurance market than are imposed by any other state. As a result, many Marylanders are unable to purchase a benefits package tailored to their own specific needs but are forced to pay for access to treatments and procedures that

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legislators target for politically favored body parts. According to a recent U.S. General Accounting Office report, Maryland's mandates add 22 percent to the cost of a typical health benefits package. This puts Maryland-based insurance plans at a competitive disadvantage when trying to attract the business of federal workers and retirees in the popular, consumer-driven Federal Employees Health Benefits Program.

- Policies that frustrate the federal medical savings account (MSA) program enacted by Congress in 1996.
- An agency that sets all rates hospitals may charge for medical services, regardless of supply and demand. Prices bear little or no relation to market forces. Under this rate-setting system, a hospital in Prince George's County charged $13,434 for an angioplasty in 1994 while one in Baltimore charged only $4,492.

HEALTH CARE SPENDING

Maryland ranks 1st among the states in Medicaid payment per child and adult beneficiary, 7th in spending on physicians' services, and 11th in spending on miscellaneous medical services. Yet its health care initiatives have done little to expand the availability of health insurance. The number of uninsured persons has climbed from approximately 570,000 in 1992 to over 700,000 today. The cost of uncompensated care reached $408.1 million in 1996 and is climbing still. And contrary to the claims of supporters of the health care regulatory system, recent figures indicate the system is not controlling hospital costs effectively. In 1996, the cost of a hospital stay increased by 4.5 percent, compared with a national average of 2.3 percent. During the second half of 1997, under the state's complicated price-fixing system, Maryland's hospitals saw their profits cut in half; 15 of the state's 52 hospitals lost money.

A BETTER SYSTEM

Excellent medical care, increased access, and a return in value for investment can be achieved only by sound policies that rely less on bureaucratic regulation and more on consumer choice and price competition. Legislators across the United States can learn what *not* to do by examining Maryland's efforts to micromanage health care through a burgeoning bureaucracy. Instead of adding more mandates and rules to an already top-heavy regulatory structure, state legislators should focus on policies that improve health care opportunities for workers and their families. Specifically, they should:

1. Promote personal ownership and portability of health insurance by giving tax credits to middle-income workers and vouchers to low-income workers.
2. Protect the confidentiality of patient records to ensure that no personal information is transmitted to any public or private entity without a patient's consent.
3. Reduce costs and replace benefit mandates with solid catastrophic coverage.
4. Eliminate outdated regulations and dismantle unnecessary bureaucratic programs.

If health care access and affordability are genuine goals, a far better approach would be to empower individuals and families to make health care choices that suit their own needs, restore the independence and integrity of the medical profession, and force insurance companies to compete for consumers' dollars. The health care delivery system at all levels should be accountable directly to the individuals and families being served.

—Dale Snyder is a Severna Park, Maryland, consultant specializing in issues related to health care and labor and employment. Robert E. Moffit, Director of Domestic Policy Studies at The Heritage Foundation and a Maryland citizen, also contributed to this paper.

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BUILDING BUREAUCRACY AND INVADING PATIENT PRIVACY: MARYLAND'S HEALTH CARE REGULATIONS

DALE SNYDER[1]

Maryland is a microcosm of many serious problems besetting America's health care system today. Doctors and patients alike are losing control, and the number of uninsured persons in the state is rising. The state's health policy—an incoherent bundle of politically driven contradictions—is driving up the cost of health care while artificially hammering down prices. In 1996, for example, the cost of a hospital stay increased almost twice as fast as the national average.[2] Such regulatory efforts have further distorted an already profoundly distorted employer-based health insurance market, giving rise to an explosion of paperwork, new problems of access and quality, and a rash of unintended consequences. Yet by mid-February 1998, 85 new health care and companion bills and 18 mental health bills had been introduced in the General Assembly.

Maryland's legislators, as well as those in other states, should ponder well the consequences of such health care micromanagement. For example:

- Officials in Maryland exercise an unprecedented level of regulatory power over the financing and delivery of health care services. No fewer than five regulatory agencies control the state's health care sys-

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1. Dale Snyder is a Severna Park, Maryland, consultant specializing in issues related to health care and labor and employment. Robert E. Moffit, Director of Domestic Policy Studies at The Heritage Foundation and a Maryland citizen, also contributed to this paper.
2. M. William Salganik, "Hospital Costs in Maryland Rise 4.5 Percent," *The Baltimore Sun*, March 6, 1997, p. 1A.

tem at a cost of over $30 million a year.[3] This regulatory behemoth was constructed layer upon layer by the state legislature, but the pace accelerated after passage of the Health Care and Insurance Reform Act (H.B. 1359) in 1993 at the height of the national debate on the failed Clinton health plan.[4] State legislators established a system whose regulatory reach is difficult even for most state legislators to comprehend. Delegate James Kelly (R-9) described H.B. 1359 as "the Clinton Plan in miniature."[5]

- Maryland officials deliberately deny the patient's right to confidentiality of sensitive medical records. In Big Brother fashion, information on patients' visits to their doctors and hospitals is being fed into a government database without their knowledge or consent. As *The Baltimore Sun* reported in late 1995, "Hundreds of thousands of patient records have been collected this year without patients' knowledge. Experts say Maryland is on the way to having the nation's biggest computerized health profile of patients and doctors."[6]
- Maryland leads the nation in the number of mandates it imposes on the health insurance market. Blue Cross/Blue Shield recently estimated that the legislature has imposed at least 42 health care mandates, and perhaps as many as 54, depending on the nature of the mandate or the type of health insurance plan targeted. This means that many Maryland citizens are unable to purchase a benefits package tailored to their specific health needs. They also are forced to pay premiums for medical treatments and procedures that legislators think are medically "necessary," including abortion, chiropractic services, or *in vitro* fertilization, whether they want them or not. Despite the fact that these benefit mandates are driving up costs sharply, Maryland legislators are proposing even more mandates. In a further limitation of patient choice, Maryland's insurance rules are still incompatible with the federal medical savings account (MSA) program enacted by Congress in 1996.[7] More specifically, state officials have attached requirements to MSAs, over and above the federal requirements, that make them prohibitively expensive.
- Maryland officials exercise a level of control over health care pricing that is unmatched in any other state. Maryland is the only state with an agency that sets the rates hospitals may charge for medical services, regardless of the market conditions of supply and demand. Besides having the government fix their rates, Maryland hospitals and medical facilities, unlike those of many other states, must file a "certificate of need" (CON) with the state bureaucracy to provide new or specialized medical services. Remarkably, the bureaucracy also is poised to impose a government fee schedule on doctors in the "private" sector that is similar to the federal Medicare fee schedule.
- Health care spending in Maryland is high. Curiously, Maryland ranks first in Medicaid

3. John Picciotto, general counsel, Blue Cross/Blue Shield, testimony before the Regulatory Task Force of the Medical and Chirurgical (MedChi) Faculty of Maryland, October 18, 1997, p. 2, in "Minutes of the Task Force" (cited hereafter as Minutes of the Task Force). The regulatory bodies are the Health Care Access and Cost Commission, the Health Resources Planning Commission, the Health Services Cost Review Commission, the Department of Health and Mental Hygiene, and the Maryland Insurance Administration.
4. Passed on April 7, 1993, by a final floor vote of 45–2 in the Senate and 117–14 in the House (10 abstained).
5. Jack Sanbower, "Beware: It's a Question of Privacy," *The Washington County Pickett*, February 16, 1997, p. 3.
6. John Fairhall, "State Collects Files on Medical Patients," *The Baltimore Sun*, December 9, 1995, p. 1A.
7. MSAs are available to those who are self-employed or who work for a company of fewer than 50 employees. Workers can save tax-free income in these accounts to use as needed for medical expenses later. However, workers must qualify by buying a compatible high-deductible health insurance policy.

payment per child and adult beneficiary.[8] And rather than promote superior private insurance options for working families, the state legislature is backing Governor Parris Glendening's proposal to expand Medicaid, a welfare program, to cover 60,000 uninsured children in those families. The state ranks seventh in spending on physicians services and 11th in spending on miscellaneous medical services.[9]

- Maryland's number of uninsured continues to grow. The state's health care initiatives have done little to improve the availability of health care for workers and their families. In fact, the number of uninsured in the state has climbed from approximately 570,000 in 1992[10] to over 700,000 today.[11]

Waste and Inefficiency

While Maryland's enormous regulatory authority is designed to "control costs," it actually has resulted in massive cost shifts, distortions in the health care sector of the market, and a rash of unintended consequences. Worse, Maryland's legislators routinely impose new mandates on the system—a propensity to regulate that continues to drive up costs at the expense of the very workers and families these same legislators represent. The result of this mania for mandates coupled with a burgeoning bureaucracy has been higher, not lower, health care costs for employers and employees alike. Miles Cole of the Maryland Chamber of Commerce has noted, for example, that a lot of the money spent on enforcing these regulations could be "better used" elsewhere.[12] To compensate for the time, money, and energy wasted in complying with bureaucratic edicts, explains Michael Preston, executive director of the state's professional medical society, "People are doing things artificially to get around the regulations."[13]

Likewise, government mandates and the standardization of health benefits not only are restricting the freedom of choice of employers, employees, and their families, but also are undermining competition in the market and driving up the cost of health care dramatically. According to a recent report by the U.S. General Accounting Office (GAO), Maryland's benefit mandates add 22 percent to the cost of a typical health benefits package.[14] Not surprisingly, Maryland-based insurance plans, saddled with state mandates, are at a competitive disadvantage when competing for the business of federal workers and retirees in the popular, consumer-driven Federal Employees Health Benefits Program (FEHBP).[15]

Sometimes Maryland's regulatory policies are contradictory. For example, the state adopted a regulation that would reduce Medicaid payments to a facility caring for the elderly if that facility is at less than 95 percent of capacity. This rule is designed to decrease Medicaid costs. At the same time, state regulators are toughening standards for private assisted living facilities that care for the elderly in home-like environments. The unin-

8. American Association of Retired Persons, *Reforming the Health Care System: State Profiles 1997* (Washington, D.C.: Public Policy Institute, 1997), p. 242. Medicaid ranking based on 1995 dollars.
9. Based on 1994 dollars. See *Ibid*., p. 239.
10. Robert E. Moffit, "Why the Maryland Consumer Choice Health Plan Could Be a Model for Health Care Reform," Heritage Foundation *Backgrounder* No. 902, June 17, 1992.
11. M. William Salganik, "Hearing Today on Help for Uninsured," *The Baltimore Sun*, February 13, 1997, p. 3C.
12. Minutes of the Task Force, p. 1.
13. Rob Kaiser, M.D., "Prognosis for Reform: Forces Converging on Health Regulators," *Washington Business Journal*, February 1997, p. 45.
14. See Carrie J. Gavora, "How Health Insurance Mandates Misdiagnose the Disease," Heritage Foundation *Backgrounder* No. 1108, April 10, 1997, p. 2. .
15. Charles Babington, "Wynn: Higher Standards Hurting Maryland Based HMOs," *The Washington Post*, August 12, 1997, p. A17.

tended consequence is that additional state-imposed regulatory costs make assisted living facilities more expensive and more out of reach for a larger number of elderly patients, who then are forced to rely on Medicaid for nursing home care. Thus, Medicaid costs go up. In speaking of the plight of private homes, State Senator Philip C. Jimeno (D-31) observes, "They've provided good quality care all these years, been affordable, and the owners are scared to death about the new regulations."[16]

The Need for Serious Debate

Health care is a $15 billion industry in Maryland.[17] Regardless of who writes the benefit checks, the money needed to fund the growing bureaucracy must come from working households in the form of higher taxes and higher health insurance premiums or lower wages. Many legislators may have the best of intentions, but they have shown little knowledge or understanding of the relationship between supply and demand in the health care market, between the enactment of mandatory benefits and higher health care costs, or between the imposition of regulations and the increase in administrative and premium costs, as well as in the numbers of uninsured. Nor do they seem to comprehend the impact that their regulatory initiatives have on the quality and delivery of health care, or the fact that they are dangerously close to "practicing medicine" with only a politician's license. Very few legislators seem to recognize that "Medical decisions shouldn't be made by politicians."[18] Said Delegate Michael Busch (D-30), who serves on the House committee that considers insurance-related bills: "We've got three doctors, and six nurses out of 188 legislators. The rest of us got our medical knowledge from *Marcus Welby, M.D.* and *Dr. Quinn, Medicine Woman*."[19]

Excellent medical care, increased access, and a return in value for investment can be achieved only by sound policies that rely less on bureaucratic regulation and more on consumer choice and price competition in a reformed health insurance market. Legislators in Maryland and across America can learn what *not* to do by examining Maryland's efforts to micromanage health care through a burgeoning bureaucracy. Instead of adding more mandates and rules to an already top-heavy regulatory structure, state legislators should focus on policies that improve health care opportunities for workers and their families. Specifically, they should:

1. **Implement policies that will reduce the number of uninsured in the state.** Legislators should promote personal ownership and portability of health insurance by giving tax credits to middle-income workers and vouchers to low-income workers so they can buy their own private health plans. In 1992, House of Delegates Speaker Casper Taylor (D-2) sponsored such a plan, based on changing the state tax code and securing waivers for changes in the Medicaid program. It won broad support in the House, and a similar consumer choice plan could win broad support again from state legislators and the public.[20] Rather than expand Medicaid, state legislators could apply such an innovative approach to Maryland's implementation of the federal Children's Health Insurance ("KidCare") Program and broaden private coverage for children.

16. Kristin Hussey, "State Rules Strain Senior Housing," *The Capital*, October 13, 1997, p. A10.

17. Angela Zimm, "Legislators Rethink Health Care Reform as Industry Prepares to Stand Its Ground," *The Daily Record*, January 14, 1997, pp. 13A–17A.

18. John Keilman, "Managed Care's Love-Hate Affair," *The Capital*, February 23, 1997, pp. A1, A8.

19. *Ibid*.

20. "It might be worthwhile to explore some type of voucher system to help families afford private insurance for their children." See editorial, "A New Health Care Entitlement," *The Baltimore Sun*, January 25, 1998, p. 2G.

2. Protect the confidentiality of patient records to ensure that no personal information is transmitted to any public or private entity without a patient's consent. Personal medical records should be given at least the same level of privacy afforded to Maryland's driving records.

3. Reduce costs and replace benefit mandates with solid catastrophic coverage. Maryland's mandates are costly and make coverage less accessible for workers and their families. Scrapping them and enforcing guaranteed insurance protection against catastrophic illness would give workers and their families freedom of choice and peace of mind. It would also be far less costly.

4. Eliminate outdated regulations and dismantle costly and unnecessary bureaucratic programs. Counterproductive programs like the certificate of need should be repealed.[21] Central planning with price controls and other cost-shifting mechanisms undermine quality care and should be abolished. Dismantling the independent commissions would eliminate counterproductive intervention in the market and force legislators to transfer productive functions (such as providing consumer information) to other established state agencies. Today's rapid changes in health care make it unlikely that politically appointed commissions can improve the efficiency and effectiveness of the private health care system.

HOW POLITICIANS SHAPE THE HEALTH CARE SYSTEM

Politics, not patient choice, is the driving force in Maryland's health care system. With the enactment of the 1993 Health Care and Insurance Reform Act (H.B. 1359), employers and employees in small businesses are legally unable to design and purchase plans that best meet their needs or wants. The landmark legislation—with components that closely resemble President Clinton's failed Health Security Act—forces Maryland's citizens to buy a government-mandated package of approved benefits, the Comprehensive Standard Health Benefit Plan (CSHBP).[22] Moreover, under the CSHBP, those who are self-employed and small employer groups find it impossible to take advantage of the new medical savings account (MSA) program enacted by Congress in the 1996 Health Insurance Portability and Accountability Act (HIPAA), the Kennedy–Kassebaum bill. The reason: The state's official policy mandates benefits with lower maximum deductibles than the federally sponsored, less expensive MSA program allows.

Political decisions have had unintended consequences for doctors and patients alike. Doctors are becoming demoralized, overly burdened with paperwork, and disgruntled. Some doctors have chosen to leave the medical profession; others are forced to become part of a health maintenance organization (HMO) as their private practice revenues fail to keep up with gross expenses. Likewise, private insurers are becoming disenchanted

21. Except possibly in a few specialized cases (for example, cardiac surgery or liver transplants) in which quality of care depends on high volume.

22. The major exceptions are workers enrolled in self-insured plans, which are governed by federal law, or the over-50 employee market. The 1993 Health Insurance Reform Act established the CSHBP for the two-to-50 employee market; it was expanded in 1995 to include the self-employed, and again in 1997 to include staffing firms and employee leasing organizations, or any type of one-person entity.

with the highly politicized regulatory environment in which they are forced to do business. Private insurance carriers, such as John Alden Life Insurance (Northstar Marketing Corporation), Time Insurance Company, and The Principal Insurance Company, have cut back on health care coverage provided to the small group market or have left the state.[23] With new mandates and additional red tape, the cost of uncompensated care in Maryland was $408.1 million in 1996.[24] And it continues to grow.

Legislating Good Intentions. Despite the unintended consequences of its policies, Maryland's state legislature seems unwilling or unable to take stock of the policy direction of its initiatives, seeing every problem it creates not as cause for reconsideration, but as an excuse to add another layer of regulation to the state's health care system. The passion for health care regulation, a preoccupation in Annapolis, has not cooled since passage of the 81-page H.B. 1359. For example, during the 90-day session in early 1997, 98 new health care-related bills were introduced in the Senate and 43 were passed. The House of Delegates considered 103 health care-related bills in 1997 and passed 45. (Some of these, of course, were companion bills.[25]) At times, the General Assembly's schedule of hearings resembled a medical school curriculum more than a legislative agenda. The annual parade of bills typically calls for changes in medical treatments or procedures that sponsors hope to mandate in every private plan.

Both the direction and shape of Maryland's health care policy are controlled by senior members of the state legislature.[26] House of Delegates Speaker Casper Taylor and Senate President Thomas "Mike" Miller (D-27) control not only who chairs and serves on what committees, but also what bills will be sent to those committees for consideration. As noted, Speaker Taylor in 1992 sponsored a very different and widely praised consumer-driven approach to health care reform, grounded in innovative changes in the tax treatment of health insurance and based on a high degree of consumer choice and market competition.[27] Nonetheless, Taylor has presided over the creation of today's highly regulatory health care regime.

The 1993 Health Care and Insurance Reform Act included a small group reform provision designed to cover firms that have between two and 50 employees. The concern was that small group employers could not obtain coverage at affordable rates without excluding employees with medical conditions. Shortly before consideration of the bill, the Speaker substantially rewrote the 81-page legislation, expanding its regulatory reach and magnitude and establishing the Clinton-style Comprehensive Standard Health Benefit Plan for private insurance plans in the small group market. Insurance carriers would be required to offer standardized benefits at an average insurance rate that would not exceed 12 percent of the state's average annual wage. In other words, Maryland imposes a "premium cap" on these plans. In addition, insurance policies would have to be issued on a guaranteed basis, which meant that no one, regardless of health status, could be turned down for coverage. Central health planning would be facilitated by the creation of a medical care data bank and the col-

23. Health Care Access and Cost Commission, "Analysis of Proposed CSHBP Benefit Changes," provided by William M. Mercer, Inc., October 7, 1997, p. 4.

24. Maryland Health Services Cost Review Commission, *Report to the Governor for Fiscal Year 1997*.

25. Maryland General Assembly, Department of Legislative Reference, *Status Report, 1997 Session*, April 7, 1997.

26. Key players include Speaker of the House Casper Taylor; Senate President Thomas V. "Mike" Miller; Delegate Ronald Guns, who chairs the Environmental Matters Committee; and Senator Thomas L. Bromwell, who chairs the Senate Finance Committee.

27. For specifics of the original market-based proposal, see Moffit, "Why the Maryland Consumer Choice Health Plan Could Be a Model for Health Care Reform." See also Carl J. Sardegna, "How the Maryland Health Plan Is a Model for the Nation," Heritage Foundation *Lecture* No. 392, May 27, 1992.

lection of medical information on patients from all licensed health care practitioners in the state.

The substantially rewritten Health Care and Insurance Reform Act was dropped on delegates' desks at 11:00 a.m. on April 7, 1993, and voted on and passed by 4:00 p.m. The Senate followed suit later that day.[28] In enacting H.B. 1359, Maryland's legislators created the Health Care Access and Cost Commission (HCACC) and gave it broad regulatory powers, similar in scope to those of agencies in states like Washington and Kentucky, both of which "reformed" their health systems in accordance with Clinton-style legislation.[29] H.B. 1359 also included a provision for the potential development and implementation of a single-payer, state-controlled health care system if a waiver from the federal Employee Retirement Income Security Act (ERISA) regulations could be obtained. (ERISA prevents states from regulating self-insured plans.)

The high degree of government control of Maryland's health care system was facilitated by the curious acquiescence of key players in the private sector—including leading representatives of the business community and the hospitals, which generally have not opposed the state's unique hospital rate-setting functions.[30] During consideration of the legislation in 1993, the Maryland Chamber of Commerce not only supported a government-standardized benefits package for small firms, but also backed the creation of new regulatory agencies and the collection of medical information without a patient's informed consent.

Ignoring Patients' Rights. Maryland has been invading patients' privacy by collecting sensitive data on every doctor-patient encounter and hospital treatment (both inpatient and outpatient encounters). In 1996, it was reported that information on about 40 percent of patients already had been entered into the database.[31] It is a great irony that under a new law passed by the same legislators who remain unconvinced of the need to protect the confidentiality of medical records, Maryland citizens have the power to protect the confidentiality of their driving records, maintained in computerized data banks at the Motor Vehicle Administration.[32]

The patient privacy debate has annoyed senior legislators since passage of the 1993 bill. During the 1997 session, Delegate James Kelly and 39 cosponsors introduced the Patient's Consent Act (H.B. 834), which would require patients to give their informed consent before detailed medical information could be entered into the state's medical care database. Speaker Taylor sent H.B. 834 to the Environmental Matters Committee, chaired by Delegate Ronald Guns (D-36), but it failed by a vote of 8 to 9. During the debate, officials of the HCACC agreed to implement additional privacy protections, including the coding of doctor and patient names. But the Medical and Chirurgical Faculty of Maryland (MedChi), the primary organization for the state's medical profession, argued

28. This rush to legislate complex health care policy and create agencies with broad regulatory powers before learning their full implications was a feature of similar measures in Washington State and Kentucky.

29. For information on the Washington State plan, see Robert Cihak, M.D., Bob Williams, and Peter J. Ferrara, "The Rise and Repeal of the Washington State Health Plan: Lessons for State Legislators," Heritage Foundation *State Backgrounder* No. 1121, June 11, 1997. For information on the Kentucky plan, see Rachel McCubbin, "The Kentucky Health Care Experiment: How 'Managed Competition' Clamps Down on Choice and Competition," Heritage Foundation *State Backgrounder* No. 1119, June 6, 1997.

30. See M. William Salganik, "Maryland Hospitals to Fight Rate Setters," *The Baltimore Sun*, April 25, 1997.

31. Jennifer A. Katze, "Who's Seeing Your Files?" *The Baltimore Sun*, July 15, 1996, p. 1F.

32. Under a state law, since September 1997, Maryland citizens can block unauthorized access to their driving records, which include information on their driving licenses, vehicles owned, and traffic violations. This information previously was available to the public for a small fee. About 1,000 motorists a day are blocking access. See Paul W. Valentine, "MD Drivers Rushing to Seal Records," *The Washington Post*, December 1, 1997, p. A1.

that even with coding, the information could be misused and privacy breached. "Doctors are very fearful and distrustful of state regulators," said Alex Azar, M.D., president of the medical society.[33]

A companion bill on patient privacy introduced by Senator George W. Della (D-47) was referred to the Senate Finance Committee, chaired by Senator Thomas Bromwell (D-8), but was held until the end of the 1997 session. The bill was voted on in committee only when it was clear that it would not pass. Opposition to the state's medical data collection policy continued to grow. Supporters of remedial privacy legislation, ranging from liberal and conservative civil libertarians to patient advocacy groups and medical societies, were able to gather 8,000 names in just six weeks during 1997 in behalf of a change in the law,[34] but even this intense petition drive failed to influence the vote in the Senate.

Mandate Mania. Maryland's state legislature has always been a lucrative target for medical special-interest groups bent on making citizens buy their services regardless of whether they want or need them. And since 1993, Maryland has continued to impose benefits mandates. The result has been rising costs. Delegate Michael E. Busch, Chairman of the House Economic Matters Committee, realizes this: "We've driven the costs with mandates through the roof."[35] Nationally, health benefits constitute 9 percent of payroll costs; in Maryland, however, health benefits make up 18 percent of payroll costs.[36] Some legislators, such as Delegate Michael A. Crumlin (D-25), admit that "Every time we pass a mandated benefit, I am not sure we legislators know the true impact on those we're trying to help."[37] As Delegate Guns stated, "Historically, it's what the state has done. We see the hot buttons and respond to them. We all know that the health care delivery system is evolving. It's a moving target."[38] Adding layers of new rules has become a recognized legislative procedure. According to Delegate Marilyn Goldwater (D-16), "There are inequities and inconsistent regulations across the system, which need to be updated and reflect current times."[39]

This environment of intense special-interest politics in the multibillion-dollar health care industry in Maryland invites corruption in the system. The temptation for policymakers to abuse their office and micromanage health care policy to benefit the competitive position of the special interests that contribute to their campaigns is great. Recently, for example, State Senator Larry Young (D-44), chairman of the powerful Senate Finance subcommittee handling health care legislation, was expelled from the legislature for using his position to obtain "tens of thousands of dollars from national health-care companies for private companies he ran from his Baltimore district office."[40] In 1996, lawmakers were concerned when Governor Glendening "solicit[ed] money from state-regulated health care groups to fund an international medical conference."[41] According to

33. Alex Azar, M.D., in testimony before the House Environmental Matters Committee, Maryland General Assembly, March 1997.
34. Christopher Unger, M.D., statement before the Senate Finance Committee, Maryland General Assembly, March 15, 1997.
35. Keilman, "Managed Care's Love-Hate Affair," p. A1.
36. Maryland Business for Responsive Government, Talking Points on health care bills considered by the 1997 General Assembly, May 1997.
37. Zimm, "Legislators Rethink Health Care Reform," p. 17A.
38. *Ibid*.
39. Angela Zimm, "Attempt to Condense Alphabet Soup of Health Care Regulators Stirs Conflict," *The Daily Record*, February 22, 1997, p. 13A.
40. Editorial, "The Saga of Larry Young," *The Washington Times*, January 24, 1998, p. D2.
41. Associated Press, "State's Role Prompting Conference Criticized," *The Carroll County Times*, July 28, 1996, p. A8.

Delegate Leon Billings (D-18), "The whole political process is now permeated with a public-private sector relationship designed to ingratiate the people with the checkbooks with the decision-makers…. This is just but a modest example of it."[42]

THE SCOPE OF THE HEALTH CARE BUREAUCRACY

Maryland's health care bureaucracy is a hodgepodge of government departments, agencies, boards, commissions, panels, advisory groups, and "work groups." Each one has authority to regulate, restrain, and direct doctors, health practitioners, hospitals, insurers, and employers. The key state agencies and departments involved in regulating the financing and delivery of health care in the state—a $15 billion industry—are:

- The Department of Health and Mental Hygiene (DHMH), which licenses and monitors quality in hospitals, laboratories, long-term facilities, nursing homes, geriatric and home health care, any type of health care facility, and HMOs. The DHMH is responsible for physician credentialing, utilization review, risk management, the rights of the mentally ill, organ donations, patient transfers, and the handling of citizen complaints and investigations. It houses 18 regulatory boards that govern doctors and medical practitioners, and whose activities are financed by fees assessed on those practitioners. Over the past two years, these regulatory boards collected approximately $18 million more in fees than their operating costs required.[43]
- Three independent health care commissions within the Department of Health and Mental Hygiene: the Health Care Access and Cost Commission (HCACC), Health Services Cost Review Commission (HSCRC), and Health Resources Planning Commission (HRPC).
- The Maryland Insurance Administration, which reviews contracts and rates of life and health insurance policy carriers, licenses insurance agents and carriers, disciplines violators, and investigates complaints from consumers other than those concerning HMOs.[44] Since contractual provisions between employers and insurance companies prevail, workers often see complaints go unresolved,[45] and there is no real consumer choice in the employer-based system when it comes to selecting a different carrier.

It is precisely because of this regulatory overkill that Maryland's health care system is known as the most highly regulated state health care system in the country. The $31 million annual cost of this system is levied on Maryland workers and their families. For example, in 1997, William Jews, executive director of Blue Cross/Blue Shield of Maryland, reported that 1.4 million of the company's subscribers alone paid nearly $2.5 million annually toward the operation of these regulatory agencies.[46] The transactional costs in time, energy, and effort for doctors, hospitals, insurers, and patients complying with the myriad of rules, regulations, and guidelines are anybody's guess.

Health Services Cost Review Commission

Since 1977, the Health Services Cost Review Commission has operated America's first and longest running hospital rate regulation program. It is now the only such program in the United States. Seven part-time commissioners appointed by the governor meet once a month to carry out the HSCRC's primary responsibility—fixing hospital

42. *Ibid*.

43. Chris Bubeck, "Agency Fees Mount $18 Million Surplus," *The Capital*, February 4, 1998, p. A3.

44. The Health Advocacy Unit of the Consumer Protection Division of the Attorney General's Office reviews complaints about HMOs.

45. Zimm, "Legislators Rethink Health Care Reform," pp. 13A–17A.

46. William L. Jews, "Maryland Would Fare Well with Less Regulation," *The Baltimore Sun*, April 20, 1997, p. F6.

rates. In theory, the panel should make sure that a hospital's total costs are reasonable and equitable, and that total charges are reasonably related to total costs. In practice, this means substituting subjective assessments for prices that otherwise would arise in a normal market.

To monitor inpatient and outpatient hospital activities, audits are performed annually at each hospital by independent certified public accountants under commission-prescribed procedures. The audits include data submitted by the hospitals in annual reports of revenue, expenses, and volume; annual wage and salary surveys; statements of changes in building and equipment fund balances; and quarterly Uniform Hospital Discharge Abstract Data Sets.

The HSCRC has been collecting information on every hospital admission for more than 20 years. The data include a patient's age, race, and sex; diagnosis; procedures performed; cost; length of stay; and insurance coverage. For about eight years, the commission has collected similar data on outpatient surgery. Regulations issued in 1996 expanded the database to include data from all doctors' offices and freestanding clinics not on hospital campuses. The HSCRC estimates that services from such offices and clinics amount to about 17 percent of hospital revenue. Interestingly, the information collected on these services and facilities even includes data that the Health Care Access and Cost Commission previously agreed *not* to collect; opponents of data collection without the patient's consent believe that this expansion of the HSCRC's authority is an end run around these earlier restrictions.[47]

Fixing Rates by Formula. The HSCRC prospectively fixes hospital rates. The rate each hospital may charge is based on a formula that produces a guaranteed inpatient revenue (GIR) charge per admission. The GIR is determined by dividing the total inpatient revenue for all diagnoses at a hospital by the total number of patients and adjusting the result for inflation and other factors. If the hospital spends less than its assigned GIR, it has saved money and will see an increase in discretionary income that otherwise would not be permitted in the HSCRC rate-setting model. The hospital can direct these funds to areas it considers to be priorities. Such rewards are seen as incentives for hospitals to reduce their costs. If the hospital spends more than its GIR, it will be penalized and the HSCRC will reduce its GIR for the following year in proportion to the amount by which the hospital has "overspent."[48] The HSCRC also adjusts hospital rates by taking into account such factors as expenses that the panel deems to be beyond the hospital's control (such as uncompensated care costs). Freestanding ambulatory care centers not associated with hospitals are not included in the rate-setting process for Maryland hospitals.[49]

The HSCRC allows hospitals to increase their rates as a "bonus" if they pursue special programs such as preventive medical services, community outreach, and education and screening for cancer, diabetes, and heart disease. This allowance is seen as an incentive for hospitals to invest resources in these kinds of programs. Since 1985, 150 hospital-

47. M. William Salganik, "Outpatient Privacy Fears Stir Squabble," *The Baltimore Sun*, September 9, 1996, pp. 17C, 19C.

48. "Guide to Rate Review in Maryland Hospitals for 1986," Maryland Hospital Education Institute (formerly the Maryland Health Care Education Institute), 1986.

49. Lawrence Pinkner, M.D., of the Maryland Ambulatory Surgery Center noted that Maryland hospitals generally get 50 percent more in reimbursement than ambulatory surgery centers because of reimbursements from the Health Care Financing Administration (HCFA), the federal agency that runs the Medicare and Medicaid programs. According to Dr. Pinkner, hospitals use these funds to underwrite their own outpatient centers. The HSCRC has no control over this process. Cited in Minutes of the Task Force, p. 2.

based prevention projects have been established in the state.[50]

Not surprisingly, left-leaning politicians and policy analysts praise this rate-setting policy for its effectiveness in "controlling" costs. Indeed, according to an analysis conducted by MedChi, "It has been described as the 'third rail' of health care regulation in Maryland, and it is treated in some circles as a near article of faith."[51] The ideologically faithful point to the fact that in recent years, according to official statistics, hospital costs in Maryland have generally fallen below the national average.

The truth is far more complicated. For example, an essential factor in assessing Maryland's hospital costs is the rapidly rising cost of uncompensated care—the dispensing of medical services to citizens who are unable or unwilling to pay for them. For the most part, no patient is denied care in Maryland's hospitals because of need. In 1996, Maryland hospitals dispensed more than $408 million in uncompensated care, an amount equal to about 8 percent of patient revenues. The heaviest uncompensated care costs hit Johns Hopkins Hospital in Baltimore and six other major hospitals that treat the majority of the state's uninsured residents. Unlike Johns Hopkins and the University of Maryland Medical System, two of the nation's premier research institutions, other Maryland hospitals do not have huge endowments to help cover the rising cost of indigent care. Nor do they have state or county subsidies or church affiliation to help them financially. They have to bear the rising costs of uncompensated care themselves. The uncompensated care percentage in 1995 ranged from a high of 25.5 percent of revenue at the University of Maryland Shock Trauma Center in Baltimore to a low of 1.32 percent at Children's Hospital in Baltimore.[52]

Driving Up Hospital Rates. Contrary to proponents' claims, recent figures indicate that the system is not controlling hospital costs effectively. In 1996, for example, the cost of a hospital stay increased almost *twice* as fast as the national average—4.5 percent compared with a national average of 2.3 percent.[53] During the second half of 1997, under the state's complicated price-fixing system, Maryland's hospitals saw their profits cut in half; during the second half of 1997, 15 out of 52 of the state's hospitals lost money.[54]

Government price-fixing is always costly. Governments normally fix prices at levels that are too high or too low; in either case, officials are endlessly engaged in readjusting these levels to reflect their idea of what a "fair" or "rational" price is outside of the market. Because officials thought that Maryland's hospital rates were too high in 1997, they proposed an adjustment in the prevailing formula (a correction factor) to reduce hospital rates by about 4 percent.[55] The manner in which the revised rate-setting formula is to be applied also means that all hospitals would not be affected the same way.

State regulators first wanted to impose this correction factor in April 1997, but hospitals warned that the state's downward pressure on rates would threaten the quality of care and make it difficult for them to finance needed improvements. A spokesperson for John Hopkins Bayview Medical Center predicted that the "correction" could cost the Hopkins medical system tens of millions of dollars in revenue. Since capital obligations cannot be

50. Health Services Cost Review Commission, "Consumers Guide to Maryland Hospitals," Revised May 1996, p. 6.

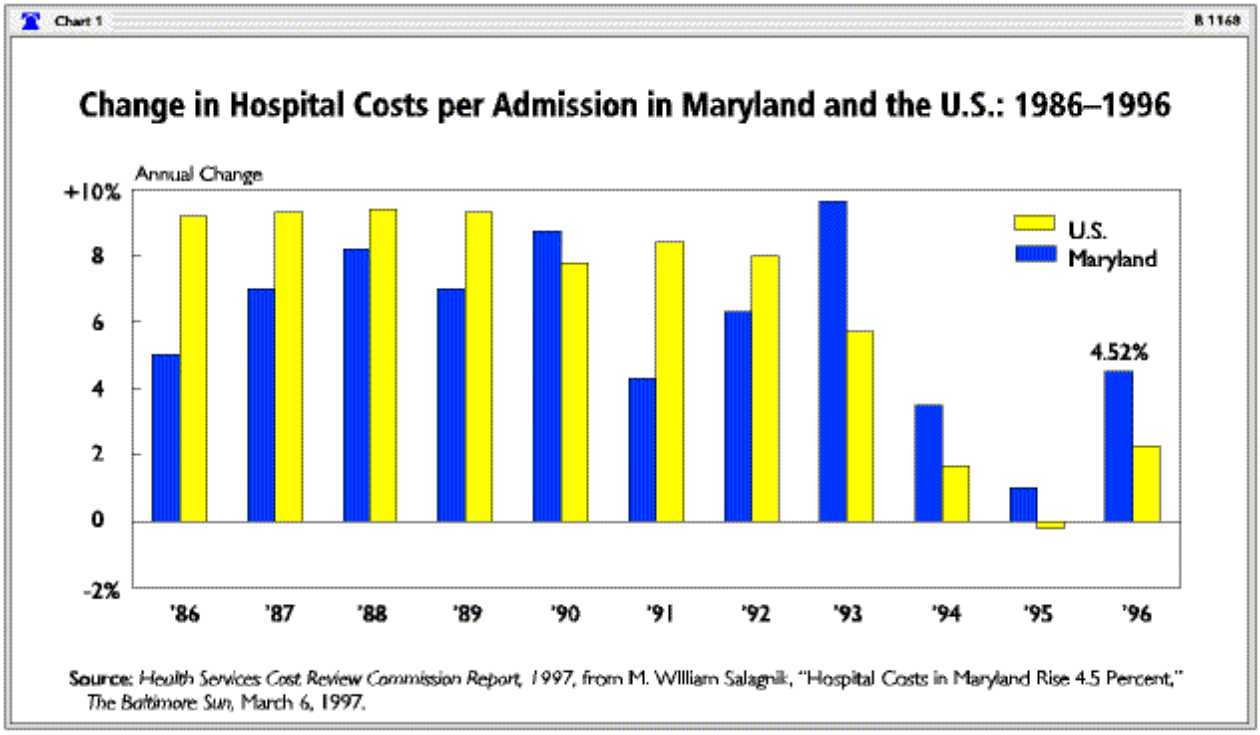
51. See "An Approach to Health Care Regulatory Reform in Maryland," MedChi House of Delegates, January 17, 1998, p. 4.

52. See Health Services Cost Review Commission, "Consumers Guide," *op. cit.*

53. Salganik, "Hospital Costs in Maryland Rise 4.5 Percent," *op. cit*.

54. Salganik, "Profit Halved at Hospitals in Maryland," *The Baltimore Sun*, March 29, 1998, p. 1C.

55. Salganik, "Hospital Coats in Maryland Rise 4.5 Percent," *op. cit*.



changed quickly, rate tightening could force very difficult trade-offs in standards of care.[56]

The Maryland Hospital Coalition, which represents two thirds of the state's hospitals, naturally opposed the new rate-setting formula. According to coalition representative Peter Parvis, "We don't think Maryland can be held hostage to the national rate of growth, because it doesn't reflect what's happening here. You can't punish an entire industry without a lot more study." The proposed formula has been projected to cut hospital revenue by about $200 million.[57] Because of pleas from the hospitals, the HSCRC agreed on May 8, 1997, to postpone the new formula and take another look at the impact of reductions in hospital revenues.

Because hospital rate-setting takes place outside of the market forces of supply and demand, the entire process—like the Maryland health care system in general—has become highly politicized. Under the proposed formula, hospitals would be pitted against each other: Some would have their rates reduced, while others would enjoy smaller rate increases than they otherwise might expect. Meanwhile, hospitals, both large and small, would be pitted against insurers, labor unions, and business leaders, such as those represented by the Maryland Chamber of Commerce. Proponents of the formula point to record hospital profits and want the commission to control costs for consumers. But hospital executives fear the climate for cost-cutting has produced tunnel vision at the expense of quality care. Chiefs of hospitals, from large urban medical centers to small rural community hospitals, told the commission that application of the formula would force hospitals to reduce staff and cut programs.[58]

Aggravating this fear is the timing of the new formula, which could become effective at the same time the state's Medicaid program switches to managed care—a change that is expected to reduce hospital profits. Already, Maryland's private-sector HMOs, scouring for claims they deem

56. *Ibid*.

57. Rob Kaiser, M.D., "Hospital Rate System Faces Scrutiny," *Baltimore Business Journal*, March 7–13, 1997, pp. 1–45.

58. M. William Salganik, "MD Hospitals Rate Formula to Get Review," *The Baltimore Sun*, May 8, 1997, pp. 1C–4C.

to be "unnecessary or inappropriate," are putting heavy financial pressure on Maryland hospitals. "The cumulative impact is far greater than the industry can absorb in a compressed time period," says Ronald R. Peterson, president of Johns Hopkins Hospital.[59]

In a normal economy, prices reflect the interaction of supply and demand. The market price is the competitive price for comparable goods or services. But prices for hospital services in Maryland's hospital market bear little relation to normal market prices (see Table 1). For example, in 1994, Prince George's Hospital Center charged $13,434 to perform an angioplasty (a surgical treatment for clogged arteries), while Franklin Square Hospital in Baltimore charged only $4,492.[60] In reporting on this discrepancy and the pricing practices of 24 other hospitals, a reporter for *The Baltimore Sun* correctly noted that, under free-market forces, "Most people probably wouldn't pay almost $9,000 more for a product than they had too."[61] Wide variances in the prices of procedures ranging from childbirth to the treatment of digestive disorders and pulmonary disease and joint replacements also were reported.[62]

Government rate-fixing is inherently inflexible and leads to odd consequences. For example, in 1996, before the legislature passed the 48-hour maternity stay law, St. Agnes Hospital in Baltimore offered, at its own expense, to pay for a free second day for mothers and their newborn infants, whether their insurance would have covered the extra day or not. Instead of applauding this effort, the HSCRC said that St. Agnes

Table 1 B 1168

Distortions in Hospital Pricing

	Hospital	Cases	Avg. Bill
Normal Childbirth	Bayview	—	**$3,202**
	Peninsula	—	**$1,679**
Cesarian Childbirth	Bayview	97	**$5,253**
	Adventist	311	**$3,775**
	Peninsula	342	**$2,873**
Psychoses	Hopkins	1,322	**$13,249**
	St. Joseph	300	**$7,820**
	Adventist	1,129	**$4,762**
Pneumonia/ Pleurisy	Adventist	179	**$7,724**
	St. Agnes	493	**$6,633**
	Bayview	236	**$5,709**
Orthopedic Surgery	Mercy	108	**$20,568**
	Holy Cross	192	**$14,901**
	Anne Arundel	245	**$12,445**
Pulmonary Diseases	Adventist	149	**$7,261**
	Anne Arundel	243	**$5,602**
	Peninsula	240	**$4,847**
Angina	Liberty	161	**$4,368**
	Union Memorial	150	**$3,724**
	GBMC	239	**$3,124**
Heart Failure	Prince George's	420	**$7,365**
	Mercy	315	**$6,517**
	Bayview	341	**$5,844**
Digestive Disorders	Liberty	92	**$6,667**
	Bon Secours	124	**$4,536**
	Bayview	156	**$3,806**
Chest Pain	Prince George's	115	**$3,377**
	Sinai	385	**$2,506**
	GBMC	353	**$2,078**

Sources: Patricia Meisol, "Maryland Hospital Costs Go Awry," *The Baltimore Sun*, October 9, 1994; data supplied by the Maryland Health Services Cost Review Commission.

59. *Ibid.*

60. See Patricia Meisol, "Maryland's Hospital Costs Go Awry," *The Baltimore Sun*, October 9, 1994, p. 1E.

61. *Ibid.*

62. *Ibid.*

needed government permission to offer the mothers of newborns such generosity.[63] After a spate of adverse publicity, the panel approved a revised "fixed price" for St. Agnes which amounted to a second day of free care for mothers and infants. At the same time, the HSCRC approved a staff recommendation that St. Agnes should be penalized for its actions and should not be eligible for any guaranteed inpatient revenue (GIR) bonus for obstetrics from February 12, 1996, to February 23, 1996—the period during which the hospital offered the free second day without the state's approval.[64]

The reality is that under government rate-fixing, more hospitals are "outsourcing" normal hospital functions, including the use of highly trained registered nurses. By using part-time agency and contract nurses, they save on the additional employee benefits they would have to pay if the nurses were full-time staff members. In some instances, the shortage of nurses and the use of non-full-time employees contributes to a lack of continuity of care for patients, even in hospitals offering such specialized care as cardiac care units for open heart surgery. More hospitals are now using nurse anesthesiologists supervised by an attending anesthesiologist who may oversee two to three operating rooms at one time. Some community hospitals send their sickest patients to larger hospitals because the larger hospitals are better equipped to treat them. When only a nighttime emergency room doctor is on staff and an inpatient's health deteriorates, on-duty nurses must find a doctor who can come in to give the patient immediate attention, taking valuable time from caring for other patients and possibly placing them at risk.

Other states have begun to recognize that removing distortions in the health care market can restrain costs more effectively than government regulators can. For example, New York, Massachusetts, and New Jersey have dismantled their rate-setting boards. Even the HSCRC has conceded that growth in hospital and health care costs continues to be a problem.[65] Ironically, it points to the historic lack of competition in the hospital industry as the primary cause of high costs.

Undermining Competition. The absence of real market competition in America's health care system is linked to law and regulation. Most citizens in Maryland and other states get health care through their employer-based health insurance in a distorted market in which there is little real consumer choice and consumers are insulated from the full costs of their care. In most sectors of the American economy, the laws of supply and demand, consumer choice, and free-market competition regulate prices. But this is not true for health care. Thomas R. Barbera, vice chairman of Mid-Atlantic Medical Services and a leader in Maryland's HMO industry, has argued that "If the commission doesn't do better than the open market, we don't need a regulatory system, and can leave the rates to competitive forces."[66] Remarkably, the HSCRC itself has acknowledged that greater competition, coupled with more informed consumers, offers the best hope for controlling Maryland's health care costs.[67] Yet the state legislature still has not crafted a policy that is even remotely in accord with this observation.

Health Resources Planning Commission

The Health Resources Planning Commission, part of the Department of Health and Mental Hygiene, is made up of 12 members who are appointed by the governor. Established in 1982 as a body parallel to the HSCRC, the HRPC's charge

64. M. William Salganik, "Maryland Rate Setters Reach Accord with St. Agnes," *The Baltimore Sun*, March 7, 1996, p. 1C.

65. Jews, "Maryland Would Fare Well with Less Regulation," *op. cit*.

66. Quoted in Salganik, "Profit Halved at Hospitals in Maryland," *op. cit*.

67. Jews, "Maryland Would Fare Well with Less Regulation," *op. cit*.

is to shape the future of the state's health care system while balancing costs and access to care, long-term care, and other health care services. The HRPC lays out its health policy agenda in its annual State Health Plan, which is based on data it has collected from various sources with input from experts in the public and private sectors. The HRPC maintains extensive databases on long-term care, home health services, hospice services, and freestanding ambulatory surgery centers. With data collected by the HSCRC and the HCACC, HRPC makes a projection of the desirable supply of health care services based on projected "need" by using methodologies developed from the database. It constantly refines its projections as the health care system changes—once again, to "control" costs.

The CON Job. Maryland has a certificate of need (CON) law that requires hospitals and physicians to file an application whenever they want to bring new medical technologies or facilities into a community. They must demonstrate to the satisfaction of government health planners that a need exists for those services and obtain state approval before implementing them. They must get, in other words, a certificate of need. This process was developed as a response to the National Health Planning and Resources Development Act of 1974, which required states to enact a procedure governing CONs or face the loss of federal health care funding. Congress enacted the legislation in 1974 when it believed that regulation, instead of market forces, was the best way to prevent the costly duplication of medical services. In 1982, Congress repealed the penalty for states without a CON program. In 1986, it ended federal funding for the CON program. Since 1993, 19 states have repealed their CON programs. Maryland, of course, is not one of these states.

Today, the HRPC reviews CON applications to determine whether the proposed private-sector investment reflects an "appropriate" use of available health resources. To achieve cost containment of hospital expenses for services provided, the HRPC sought the use of mergers, consolidations, and closures to (in the jargon of the day) "right size" Maryland's health care system. However, it is presiding over the implementation of a process that makes it difficult, if not impossible, for innovative health care entrepreneurs to develop and market better technology and competitive services.

Since the CON process could lead to the denial of permission for new equipment or facilities, it gives older facilities a virtual monopoly on special services, especially hospitals that developed subacute care beds. Restricting supply in this fashion undermines market incentives to control costs. As Wayne Spiggle, M.D., noted in his remarks before MedChi's Regulatory Task Force in 1997, certificates of need have been used to preserve hospital monopolies.[68] And as an attorney representing physicians who deal with CONs also noted, the process does not always benefit rural areas; it was used, for example, to block the expansion of a hospital in rural Berlin, Maryland.[69]

Hospitals and other medical facilities pay a substantial compliance cost in the time and financial resources needed to prepare the CON application. Many hospitals, including some in the inner city of Baltimore, lack the resources and political clout to compete for advanced medical technology. For example, some inner-city and rural hospitals in Maryland have not obtained CT scanners because community hospitals already have exhausted the officially determined supply and the state bureaucracy will not issue more certificates.

The CON policy is also designed to limit state Medicaid costs by limiting the number of available beds in all hospitals. But by limiting the number of beds in nursing homes, for example, the bureaucracy inadvertently increases private care prices for patients in nursing homes, negatively affecting elderly patients. Higher private care prices mean that patients, who generally are elderly and have limited assets, will spend down and become eligible for Medicaid sooner. For elderly patients, this is

68. Minutes of the Task Force, p. 3.

69. *Ibid.*

personally disastrous, for it reduces their quality of life and contributes to a loss of self-esteem and financial assets while increasing costs to taxpayers. Furthermore, Maryland's elderly population, like the nation's, is growing rapidly. This fact implies that any short-term cost savings derived from the CON process could lead to a net increase in Medicaid costs.

Furthermore, the CON process has done little to solve the problem of excess hospital capacity. With the shift to managed care, excess capacity has become an even greater problem. Indeed, the average occupancy rate is slightly better than 50 percent.[70] Thus, Maryland's hospital CON regulation, like its hospital rate regulation, has contributed to unintended and somewhat perverse results. Overall, regulation of the availability of competitive facilities has restricted the market, reduced quality, and increased costs.

Health Care Access and Cost Commission

The state legislature established the Health Care Access and Cost Commission in 1993 by enacting H.B. 1359.[71] The commission's nine members are appointed by the governor with the advice and consent of the state Senate; it has a staff of 32. Only three members may have any connection to the policy or management of a health care provider or payer. Members serve a maximum of two consecutive four-year terms. The HCACC has broad regulatory authority to develop and carry out new state health care policies, such as:

- The Comprehensive Standard Health Benefit Plan (CSHBP);
- A database on non-hospital health care services;
- Oversight of electronics claims clearinghouses;
- A payment system for all health care practitioner services;
- Practice parameters for physicians and surgeons; and
- Quality and performance measures for HMOs.

The HCACC is funded by "assessments" (in effect, special taxes) levied on doctors, hospitals, and insurance companies. Currently, one third of these assessments is extracted from practitioners and two thirds from third-party payers. The assessments on payers are apportioned among two classes: carriers (such as HMOs, insurers, and nonprofit health service plans) and third-party administrators registered with the Maryland Insurance Administration. Maryland law caps the total amount the HCACC can assess at $5 million annually. The initial $5 million for start-up costs was appropriated from state tax revenues by the legislature.

Standardizing Health Benefits. The HCACC's major initiative has been the development of the Comprehensive Standard Health Benefit Plan. As of July 1, 1994, Maryland insurance carriers had to offer the CSHBP to any small business (with between 2 and 50 eligible employees) choosing to offer health benefits on a guaranteed issue basis without pre-existing exceptions after January 1, 1995. Carriers could underwrite additional benefits, such as group life insurance coverage, dental insurance, and group disability benefits. In 1995, small business coverage was extended to the self-employed; in 1997, it was extended to any type of one-person entity[72] and employees of staffing firms or employee leasing organizations with 2 to 50 employees.[73]

Building the Government's Database. Perhaps the HCACC's most controversial task is the gathering of personal information for the state's medical

70. Jews, "Maryland Would Fare Well with Less Regulation," *op. cit*.

71. Overview, Health Care Access and Cost Commission, September 1996; cited hereafter as "Overview."

72. Maryland General Assembly, H.B. 211, Maryland Health Insurance Reform, Application to Self-Employed Individuals, and S.B. 69, Small Employer Group Health Insurance, Small Employer Definition, 1997 Legislative Session.

73. Maryland General Assembly, H.B. 213, Small Employer Groups, Health Benefit Plans, 1997 Legislative Session.

care database without patients' consent. Commission officials say this database will help them bring health care costs under control by allowing them to examine costs and by giving purchasers a way to measure a doctor's performance against government norms. The HCACC is supposed to publish an annual report describing total reimbursement for all health care services and for each health care specialty, the geographic variation in expenditures and utilization of services, and variations in fees charged by doctors, medical specialists, and facilities. The database, they claim, also will enable doctors and hospitals to assess the productivity of their practices relative to others and provide comparative information on services by specialty and region. Critics see a different agenda: an instrument to monitor medical procedures that allows state officials to control medical treatments.[74]

Standardizing Electronic Claims Processing. The HCACC is also responsible for establishing standards for the operation of private-sector medical care electronics claims clearinghouses and electronic health networks. It has been given broad flexibility to establish regulations for implementing incentives to encourage the health care market to operate more efficiently. In 1995, the HCACC concluded that a mandatory approach based on the licensing of electronic health networks and the adoption of electronic data interchange by doctors faced insurmountable obstacles. It developed a strategy based on the "certification" of electronic health networks and the voluntary adoption of electronic data interchange by doctors. This approach tied voluntary participation to such economic incentives as faster reimbursements for services rendered and less paperwork, which also would increase payments from insurers.

The HCACC has established a voluntary start to the certification program for electronic networks in 1996. The HCACC also would "certify" networks that satisfied its requirements but would not prevent other electronic health networks from operating in the state. Certification would be based upon standards developed by the Electronic Health Network Accreditation Commission, a private industry group which would police the electronic health networks and set operating standards based on "best practices." This arrangement would allow private-sector input in a complex public policy issue area; however, it also could allow private interests to become the judges of their own causes with the powerful instrument of government to advance them.

The HCACC's electronic data interchange regulations impose yet another government mandate on insurers. To encourage voluntary certification, insurers must designate at least one certified network to accept their electronic claims. In 1997, the state legislature passed a bill to allow the HCACC to delay implementation until 1999.[75] Under its regulatory regime, the designation requirement would not preclude companies from dealing with non-certified electronic health networks, but they must use at least one that is government-certified. Finally, insurers would be required to submit an annual progress report covering their claims activity. HCACC officials see certification as a positive step toward building a stable health care data infrastructure, which would be modified by evolving national standards or what corporate and government experts redefine as "best practices."

Report Cards on Quality Standards. The original 1993 legislation also required the HCACC to evaluate the quality of care and the performance of HMOs. HMO evaluation involves performance measures according to the Health Plan Employer Data and Information Set (HEDIS) published by the National Committee of Quality Assurance (NCQA) and enrollee surveys. In the future, practitioner surveys also would be involved. The NCQA accredits the health plans based on 50 standards that measure performance in quality improvement, physician credentials, members'

74. Bridget McMenamin, "It Can't Happen Here," *Forbes*, May 20, 1996, pp. 252–253.

75. S.B. 97, Maryland Health Care Access and Cost Commission: Modification and Clarifications, passed April 1997; S.B. 314, Health Care Access and Cost Commission, Sunset Review, passed March 1997.

rights and responsibilities, preventive health services, utilization management, and medical records.

A common set of performance measurements was supposed to improve the quality of HMO care. It was also supposed to give employers and employees cost information and reports on the quality and performance of their HMOs. In 1997, the HCACC published its first report card on the performance of 15 HMOs licensed in Maryland. Although the report card process generally won the approval of state officials and health policy analysts,[76] consumer use of the information continues to be limited by the practical inability of most workers and their families to hire and fire their health insurance companies.

Fixing Doctor's Fees. The 1993 legislation required the HCACC to develop a payment system for all health care practitioners in the state by January 1, 1997. This monumental task has been delayed, however, and a new date of January 1, 1999, has been set by legislation.[77] The proposed payment to doctors will be determined without regard to the market forces of supply and demand. Three numeric factors will be calculated to determine a doctor's reimbursement: the "resources" a doctor needs to provide services relative to other doctors; the "value" of a doctor's service relative to other health care services; and a "conversion modifier" to convert the formula to a dollar amount. The HCACC will establish the factors that determine a practitioner's resources and the "relative value" of the medical services provided, based on social science measurements, and periodically will adjust the conversion modifier downward, thereby cutting doctors' reimbursements if the state's annual health care "cost control" goals are not met.

The 1993 statute directed the HCACC to consider the social science methodology of the federal government's Resource-Based Relative Value Scale (RBRVS), currently used by the Medicare program.[78] The underlying premise of this system is that a service has an objective value relative to other health care services. Through a formula, the government can convert that value to a dollar amount, and a fair and rational price can be derived. Under the RBRVS, the Medicare planners' key assumption is that they can discern how a doctor should be paid by statistically measuring the "value" of a doctor's "work" by calculating the time, effort, and skill that goes into providing a medical service. Yet, from the standpoint of economic theory, such an updated version of the old labor-based theory of value makes little sense. In the words of Stuart M. Butler, vice president of The Heritage Foundation, "The idea of objective value and prices is entirely rejected in market economics, which forms the basis of western economies. Instead, flexible prices, reflecting supply and demand amid the differing subjective valuation attributed to goods and services by individuals, is key to efficient production, distribution and exchange in an economy."[79]

Maryland's proposed government fee system for doctors, like many other regulatory initiatives, is designed to control health care costs. When it is fully developed, it will be used as the complex Medicare fee system is used: to measure the volume and relative cost of medical services in order to establish a mechanism for adjusting payments to doctors and to serve as a basis for a utilization

vert News: A Journal of Maryland Policy, Vol. 2, No. 4 (Fall 1997), pp. 12–13.

77. S.B. 314, *op. cit.*

78. For a description and critique of the Medicare RBRVS, see Robert E. Moffit, "Back to the Future: Medicare's Resurrection of the Labor Theory of Value," *Regulation,* Vol. 15, No. 4 (Fall 1992), pp. 54–63.

79. Stuart M. Butler, "The Fatal Attraction of Price Controls," presentation at a conference sponsored by the American Enterprise Institute, Washington, D.C., April 21, 1993, p. 3.

analysis by government-selected experts, businesses, insurers, and HMOs. Thus, it will be used as the basis for payments made to doctors by insurers and HMOs. For purposes of its application, "practitioners" would include all licensed health care practitioners such as physicians, dentists, social workers, therapists, pharmacists, and advanced practice nurses.

The HCACC set up a Payment System Advisory Committee (PSAC) to oversee the development and implementation of this fee system. The PSAC is comprised of 24 members, including physicians and other health care practitioners as well as representatives from the insurance industry, employers, labor, and the public. In 1995, the HCACC contracted with the Center for Health Economics Research (CHER), a Massachusetts-based health policy research firm, to recommend the design of the new payment system. The CHER has extensive experience with the application of the Medicare RBRVS to state agency programs. Initially, the proposed payment system would be imposed primarily on physicians and certain other "limited license practitioners," including doctors of optometry, podiatry, and chiropractic medicine. Eventually, it would apply to all practitioners.[80]

Practice Guidelines for Doctors. The HCACC was required by H.R. 1359 to develop "practice parameters" for Maryland's doctors, including "strategies for patient management" and treatment guidance. "Practice parameter" is an umbrella term that covers such things as clinical "practice guidelines," practice "protocols," practice "standards," and "care pathways."

Curiously, members of the state's medical profession were the driving force behind this provision. For some, it was a way to preserve a standard of care which they believed to be threatened by HMOs. Others had a different reason: They wanted to protect themselves from excessive malpractice litigation by practicing only state-adopted practice parameters of care. Instead of establishing practice parameters for lawyers who vigorously pursue medical malpractice cases, legislators decided to establish practice parameters for doctors. Not surprisingly, lawyers used the doctor's reliance on "official" practice parameters as a defense against allegations of malpractice. Maryland law, however, does not hold that "practice parameters" adopted by the HCACC are admissible in such legal proceedings as evidence of care.

Because of the complex and innumerable questions surrounding the use of practice parameters for doctors, the HCACC created the HMO Quality and Practice Parameter Development Work Group in 1993. This group, in turn, recommended that the governor appoint a special Advisory Committee on Practice Parameters (ACOPP). Governor Parris Glendening complied with that request in April 1995. Since then, the special 15-member ACOPP, chaired by a practicing pediatrician, has studied the process for adopting and using practice parameters. It is focusing on such areas as cardiology, emergency room medicine, obstetrics and gynecology, orthopedics, and pediatrics. Specific areas include childhood asthma, back pain, chest pain, and cesarean section. The ACOPP looked at how practice parameters are used and developed, particularly in malpractice litigation, while developing statewide practice parameters through task forces consisting of members of various professional societies.[81] J. Ramsey Farah, M.D., committee chairman, wants to change Maryland law so that the HCACC's guidelines will legally "supersede" all others.[82]

A Super-Regulatory Agency. A broader problem for Maryland's doctors and patients is whether any government agency should be allowed to determine what treatment is appropriate without regard to a doctor's professional judgment about the patient's health. Faced with the persistent pressure to control costs, the health care bureaucracy is constantly tempted to develop regulatory mech-

80. Overview, *op. cit*.

81. *Ibid*.

82. Minutes of the Task Force, p. 1.

anisms to ensure that expenses will not become too great. And their determination is based on estimates made without reference to market conditions. In essence, the HCACC could become the government's "gatekeeper," controlling patients' access to practitioners, specialists, and treatments—matters previously determined by doctors and medical specialists who are morally bound by the Hippocratic Oath to offer the best treatment for their patients.[83] Beyond the potential reduction of quality and innovation in clinical practice, such a bureaucratic process would seriously undermine the fundamental relationship between doctors and their patients.

The HCACC, like certain employer-based managed care companies, could come dangerously close to micromanaging medical practice. Taxpayers and health care professionals are right to wonder how a state commission can codify medical standards into law or implement them through regulations when medical science itself is constantly evolving and undergoing rapid technological advances.

THE LOSS OF PATIENT PRIVACY

Today, Maryland collects medical data without informed patient consent.[84] When a patient is treated in a hospital, the information collected includes the patient's unique medical record, including diagnosis, procedures performed, and prescribed medication, as well as personal demographic characteristics. Unless this policy is reversed, detailed information on every patient visit with a doctor or medical practitioner and any type of hospital treatment (excluding self-pay patients) will be collected and fed into a database without the patient's being able to verify its accuracy or give consent.

In February 1995, the HCACC began to collect information for the database. It began with existing information from insurers with formal respect for the privacy of individually identifiable information. Today, the data collection regulations require payers to submit "encounter information" on all fee-for-service encounters, on all specialty care capitated encounters, and for primary care physicians reimbursed under capitated arrangements. Because there is no practical way to collect data on self-pay encounters (patients who pay the doctor directly out of pocket), surveys will be administered to doctors to estimate patients' self-pay expenditures. Based on these efforts, the commission will report on expenditures and utilization. Although it collects some billing data from insurers, the HCACC draws on other data sources and uses statistical techniques to make estimates in areas where it cannot collect data directly, such as spending for health costs not covered by insurance and hospital services purchased by Marylanders out of state.[85] Interestingly, none of this data collection includes information regarding the "outcome" of treatment.

In response to legislative concerns in 1996, the commission eliminated information on the patient's race and limited birth information to month and year of birth. It also removed the encrypted patient identifier (generally, the patient's Social Security number) after the data had been edited. Meanwhile, a commission work group has been appointed to address confidentiality issues raised by some legislators under pressure from patients.

In September 1996, the HSCRC announced that it wanted to include outpatient treatment at hospitals in its database (it has collected inpatient hospitalization data for about 20 years). The HSCRC would collect race information and more precise data on patients as well as information on those who pay for their own care—information the HCACC previously had agreed not to collect. Directors of the two commissions say they need the data to help control health care costs and insist that there is no intent to have one agency collect

83. Overview, *op. cit.*

84. McMenamin, "It Can't Happen Here."

85. M. William Salganik, "Health Care Cost Rise Moderated in 1995," *The Baltimore Sun*, April 1997, pp. C1, C8.

what the other has promised not to collect. But an inherent conflict of interest arises when an agency that is supposed to guard patient privacy decides that it needs to collect as much data as possible to control costs. Doctors take an oath to recommend the best treatment for a patient, not treatment that is the least costly. With the state monitoring their decisions, however, they may feel compelled to choose tests or procedures that cost less, even when the patient is paying for it.

Before long, every doctor, chiropractor, psychologist, and psychiatrist will be required by the state to report patient visits to the data bank, and the state will accumulate a dossier on every resident—a dossier, moreover, that has not been checked for accuracy by the patient. For each medical claim, an insurance carrier would be forced to give the state up to 34 bits of personal information, including a patient's diagnosis and treatment, patient identifier or Social Security number, month and year of birth, sex, race, Zip code, the claim control number, date of the visit, location of the doctor's office, and the doctor's federal tax identification number.[86] The Maryland Psychiatric Society, among others, has asked the state legislature to require a patient's approval for the release of such information. But HCACC director John M. Colmers told a House committee in 1997 that collecting information only from consenting patients would "bias" the data and that verifying their consent would be costly and burdensome to government officials.[87]

Because medical data represent a valuable commodity, the desire to have access to this information is growing among HMOs, pharmaceutical companies, medical equipment manufacturers, and researchers.[88] As noted by Daniel S. Greenberg, editor of *Science and Government Report*:

> Frolicking teenagers occasionally bust into the computer systems of the Pentagon, banks and other supposed bastions of electronic security. If they can do it, what's to prevent intrusions into computerized medical records by nosy employers, anxious lovers, professional rivals, crafty salesmen and curious kooks? Actually, very little. Over the past decade, that's been the consistent conclusion of a variety of studies by specialists in medicine, law and computers.[89]

Even if data were somehow made secure from internal theft, the very existence of such a government database is a threat to privacy and personal liberty. Medical diagnoses and treatments are highly personal, and such information can be misused in destructive and discriminatory ways. According to a May 1996 *Time-CNN* survey, 87 percent of the American people say they want to give permission before their personal information is included in any database. Doctors fear that a large number of patients—particularly patients being treated for sensitive conditions, such as psychiatric patients—will avoid medical treatment if they cannot be assured of confidentiality, and that their conditions consequently will become worse. This will guarantee increased costs of disability, morbidity, and mortality, and ultimately higher health care costs for the state as well—another unintended consequence of Maryland's over-regulation. Yet an insufficient number of Maryland legislators appear to be concerned about these problems.

An Instrument for Central Planning. A key clause in the 1993 Health Care and Insurance Reform Act holds that information cannot be collected with identifying information. This means, according to some analysts, that state officials may not obtain a person's name and address. But they

86. McMenamin, "It Can't Happen Here."

87. M. William Salganik, "State's Data Agency to Offer Patient Privacy Safeguards," *The Baltimore Sun*, May 9, 1996, pp. 1C, 10C.

88. Reuters, "Protecting Medical Records," *The Washington Post*, December 22, 1996, pp. C1, C3.

89. Daniel S. Greenberg, "Who's Looking at Your Medical Records?" *The Baltimore Sun*, August 6, 1996, p. A-7.

can, and do, collect a person's patient identification number from his insurance card. Often, that includes a Social Security number, which can be used to find out a patient's name, race, age, sex, driving record, and other personal information.

State health officials advance various arguments to defend the collection of patient data. Robert B. Murray, executive director of the Health Services Cost Review Commission, says the purpose of the data collection is to allow the state to do research and promote health care cost containment (often a euphemism for price controls).[90] But such a "research" agenda implies special obligations to the subjects being studied. If the argument for patient data collection is research, then state officials should admit their responsibility for ensuring ethical standards. The most prominent principle is the ethical standard of obtaining the informed and voluntary consent of human research subjects. Unless this is done, by the standards of scientific research on human subjects, the state is violating a deeply held code of ethics, as well as the democratic principles of personal privacy and freedom of choice.

If the data were collected with a patient's consent, maintaining the security of the database should be paramount. Remarkably, HCACC Director John Colmers admits there is no guarantee of data security.[91] As Paul Clayton, chairman of the National Research Council panel on medical privacy, has stated, "Medical records are vulnerable to invasions of privacy in the computer age, but today there are no strong incentives to safeguard patient information because patients, industry groups, and government regulators aren't demanding protection."[92]

The real objective in collecting patient data appears to be even greater state control of the health care system, and comprehensive data collection certainly furthers that objective. Not surprisingly, HCACC officials want details on every health care encounter to help them plan and control costs. The database would help these officials identify practitioners who, in their judgment, are inefficient providers or guilty of rendering expensive treatment unnecessarily. Ironically, data generated from insurance claims forms today are often found to be unreliable for this purpose.[93]

House Speaker Casper Taylor is a strong supporter of the state's data collection effort. "Our main purpose is to keep legislators focused on the evolution in health care," says Taylor. "It's very complex, it's a huge percentage of the gross domestic product, and it changes so rapidly that we want to stay ahead of the curve."[94] Taylor opposed patient consent legislation precisely because it could weaken and unravel the planning capacity of the HCACC, a key component of the regulatory regime he helped establish in Maryland. In the policy conflict between securing personal privacy and facilitating central planning, therefore, personal privacy is sacrificed.

BENEFITS BY MANDATE

As Maryland's legislators delve into micromanaging health care, they are seriously affecting the practice of medicine itself. Thus far, the state has imposed at least 42 specific mandates covering insurance benefits or medical treatments. The actual number of mandates varies, depending on how the HCACC defines them and how the state legislature has targeted the insurance carriers. The rules differ for HMOs, nonprofit insurance carriers, and group and individual insurance. Plans serving Maryland's small group market, of course, are subject to the Comprehensive Standard Health Benefit Plan, which, by the author's count, con-

90. Salganik, "Outpatient Privacy Fears Stir Squabble, *op. cit*.

91. John M. Colmers, testimony before the Senate Finance Committee on S.B. 813, Patients' Consent Act, March 13, 1997.

92. Reuters, "Medical Data Security Law, Panel Warns," *The Washington Post*, March 6, 1997, p. A17.

93. Greenberg, "Who's Looking at Your Medical Records?"

94. Angela Zimm, "Legislators Rethink Health Care Reform as Industry Prepares to Stand Its Ground," *The Daily Record*, January 14, 1997, pp. A3, A13.

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Maryland State-Mandated Benefits and Providers

Benefits	Mandate Enacted
Benefits	
Alcoholism Treatment	1988
Breast Reconstruction	1996
Diabetic Supplies	1997
Drug Abuse Treatment	1988
Home Health Care	1982
Hospice Care	1982
In Vitro Fertilization	1989
Mammography Screening	1991
Mental Health Care	1993
Minimum Maternity Stays	1996
Off-Label Drug Use	1994
Orthotic/Prosthetic Care (1996 Survey of Plans)	1978
Well-Child Care	1992
Providers	
Chiropractors	1973
Dentists	1973
Licensed Health Professionals	1983
Nurse Anesthetists	1984
Nurse Midwives	1978
Nurse Practitioners	1979
Nurse, Psychiatric	1983
Occupational Therapists	1983
Optometrists	1973
Osteopaths	1973
Physical Therapists	1983
Podiatrists	1973
Professional Counselors	1985
Psychologists	1973
Public [Health] and Other Facilities	1982
Social Workers	1977
Speech/Hearing Therapists	1983
Persons Covered	
Continuation/Dependents	1977
Continuation/Employees	1979
Conversion to Non-Group	1979
Handicapped Dependents	1977
Additional Benefits	
Alzheimer's	1986+
Blood Products	1975
Catastrophic	1978+
Cleft Palate	1982
Emergency Services	1996
Formula for Phenylketonuria (PKU)	1995
Mental Illness Parity	1994
Physician Assistants	1986

Note: + Indicates that the mandate has to be offered only to groups/individuals, as opposed to a mandated requirement.
Source: Blue Cross/Blue Shield Association, "1997 Survey of Plans," *State Legislature Health Care and Insurance Issues*, January 1998.

tains 54 specific benefit and insurance mandates (see Appendix). In any case, these mandates have been driving up health care costs across the state. And last year, they compromised the ability of Maryland's health companies to compete for the business of federal employees and retirees enrolled in the popular Federal Employees Health Benefits Program. U.S. Representative Albert R. Wynn (D-MD) complained to the director of the U.S. Office of Personnel Management that OPM's decision to require Maryland plans to offer the mandated benefits undercuts those businesses: "Since cost is a critical factor in health plan choice, this creates a competitive disadvantage for Maryland-based companies."[95]

Perhaps the most significant example of micromanagement has been the state's standardization of benefits in the CSHBP for the small group market, which went into effect in 1994. The initial benefit plan included one set of benefits that were applicable across four delivery systems (indemnity, preferred provider, point-of-service wrapped around an indemnity delivery system, and HMOs). Each delivery system had different cost-sharing arrangements. The CSHBP would provide preventive services for HMOs and protection against catastrophic expenses for traditional insurance companies (see Appendix).

The 1993 Health Care and Insurance Reform Act governing the small group market also established a benefit floor (as the actuarial equivalent of the benefits provided by a federally qualified HMO), as well as a ceiling on the average rate of the plan (12 percent of the state's average annual wage). The state's average wage for 1995 was slightly more than $29,000, making the cap about $3,500. Yet the average cost of delivery ranged from $3,615 (indemnity) to $2,738 (HMO). In 1996, the average wage was $29,560; at 12 percent, the cap was about $3,600, while the average cost of delivery ranged from $3,888 (indemnity) to $2,743 (HMO). Projected rates in 1998 are about $4,700 for indemnity to $3,000 for an HMO.[96] Indemnity plans are struggling to survive in this atmosphere.

Some insurance carriers today offer only the Comprehensive Standard Health Benefit Plan. Consequently, passage of the Health Care and Insurance Reform Act has caused some employees in Maryland to lose benefits. Their employers could no longer design health care plans based on their needs and could no longer offer them the flexibility of being able to choose between higher deductibles or co-payments or paying out of pocket for medical expenses.

In addition, some benefits covered prior to 1993 were excluded in the CSHBP, and some lifetime benefits were reduced. The legislature added an additional delivery system (a triple option point-of-service) in July 1996 and a 48-hour hospital stay for normal deliveries or a 96-hour stay for cesarean section deliveries. The 1997 legislative session expanded the CSHBP mandate to the self-employed and enacted four new health insurance mandates. According to the official HCACC analysis, these new mandates will have only a 0 percent to 2 percent impact on current and projected rates.[97] Official government estimates of health care costs tend, of course, to be conservative.

Initially, more than 60 insurance carriers were selling the CSHBP to small businesses in Maryland. Many offered HMO and preferred provider organization (PPO) plans with an out-of-network option. But insurance carriers reportedly are withdrawing from the small-employer group market because of premium restraints, the guaranteed issue requirements for mandated benefits, and the

95. Babington, "Wynn: Higher Standards," citing a letter from Representative Albert R. Wynn (D-4th) to Office of Personnel Management Director James B. King.

96. "Maryland's Small Group Market, Summary of Carrier Experience for the Calendar Year Ended December 31, 1996," Staff Report to the Health Care Access and Cost Commission, June 5, 1997, p. 2, exhibit 1.

97. Health Care Access and Cost Commission, "Analysis of Proposed CSHBP Benefit Changes," pp. 1–4, exhibits.

continuing enactment of additional mandated benefits.[98]

Some small employers are trying to take advantage of a legal loophole in the 1993 legislation to avoid state benefit mandates. They are adopting self-insured plans with high deductibles and using an administrative firm to process claims, shifting most of the risk to the insurer.[99] In the course of litigation on this matter, U.S. District Judge Alexander Harvey ruled on February 23, 1996, that Maryland had overstepped its authority in issuing new regulations to set limits on companies that self-insure health plans for their employees, and that these regulations conflict with the federal Employee Retirement Income Security Act, which prevents states from regulating self-insured plans. The Maryland Insurance Commissioner appealed this decision and lost. On August 9, 1997, the Maryland Insurance Administration petitioned the Supreme Court to hear the case.[100]

During the 1997 session, lawmakers passed a bill establishing medical savings accounts (MSAs) for the small group market to comply with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HCACC is authorized to establish a modified health benefits plan with a high deductible for the small group market with MSAs that qualify under the HIPAA, and is charged with designing and implementing the new plan.[101] Insurance carriers in Maryland who offer the new (high-deductible) modified benefit plan also must sell the state's Comprehensive Standard Health Benefit Plan. Not surprisingly, according to an October 1997 report issued by William M. Mercer, Inc., a large national benefit planning and consulting firm, MSAs have not been as popular in Maryland as anticipated.[102] Moreover, the attractiveness of MSAs for small businesses, both in Maryland and elsewhere, has been compromised by the level of regulation imposed by Congress in the Kennedy–Kassebaum legislation.[103]

Legislative mandates have other drawbacks beyond increased costs. They lock in coverage of medical treatments, even if the progress of medical science and clinical practice renders them practically obsolete. Legally mandating more benefits means that workers and their families cannot buy the packages of benefits they want. But in the heat of the legislative moment, state legislators seem unable to resist the temptation to legislate mandates. Thus, in 1997, legislators mandated prostate screening, diabetic equipment and supplies, and bone mass measurement to guard against osteoporosis. In 1998, they enacted mandatory coverage for contraceptives and for treatment of cleft palate: The Senate voted for the cleft palate measure by 46 to 0; the House, by 126 to 6.[104]

Although some Maryland legislators have expressed misgivings about standardizing or specifying the benefits, treatments, or medical procedures that should be included in private health plans, bills introduced to address the problems created by such mandates invariably have failed. One such bill, for example, authorized a comprehensive review of the social and financial impact of

98. *Ibid*., p. 4.

99. Self-insured plans are exempt from the jurisdiction of state agencies and do not have to abide by any of the rules that apply to health plans regulated by the state, such as financial solvency standards or state-mandated benefits.

100. *Maryland Insurance Commission vs. American Medical Security Insurance Co., Larsen vs. American Medical Security,* S.C. 97-218. From phone conversation with Maryland Attorney General's Office, February 18, 1997.

101. H.B. 843, Health Insurance—Small Group Market—Medical Savings Accounts, passed April 1997.

102. "Maryland's Small Group Market," p. 7. Mercer recommended that the CSHBP have high deductible options ($1,500 to $2,250) through a PPO plan, which would not have a significant impact on the composite rate of the CSHBP. Policyholders could purchase riders for lower deductibles. To date, no MSA plan is available for Maryland's small group market.

103. "After a year on the market, one thing we know is that the HIPAA MSA is far too complex and rigid." See *Patient Power Report*, Vol. 3, No. 1 (February 1998), p. 15.

104. Samuel Goldreich, "HMOs Pursue Second Opinion on Mandates," *The Washington Times*, March 23, 1998, p. D16.

any proposed mandate and a clear analysis of the public health reasons for its enactment.[105] A committee formed in 1992 to review mandated benefits met for two years and then folded. "Everybody was holding tight to their own turf," said Delegate Adelaide Eckardt (R-37B). "It became very political."[106]

THE MARCH TO MANAGED CARE

Maryland ranks fourth in the nation in the percentage of its population (30.9 percent) enrolled in HMOs.[107] What the raw numbers do not reveal is that many people in managed care plans are enrolled not by personal choice, but by the choice of their employer. It is a business decision, not a consumer decision.

Expanding Managed Care in Medicaid. Maryland aggressively promotes managed care for poor families. The $2.3 billion annual Medicaid program is the single largest item in the state budget. With the receipt of a federal waiver from the Clinton Administration in 1996, all Medicaid recipients in Maryland are required to enroll in managed care. The state started enrolling 330,000 additional Medicaid recipients into six managed care organizations in 1997.

The state legislature has converted Medicaid from a fee-for-service system to a system with "gatekeepers" who manage medical referrals. Maryland has required managed care organizations that want to obtain contracts for Medicaid recipients to create partnerships with a group of community health centers throughout the state. This program, called Priority Partnerships, would get capitation payments from the state—a flat fee per month for each patient it enrolls. The shift is expected to save nearly $500 million between 1997 and 2001.[108] The new Medicaid-managed care program reportedly is experiencing difficulties.[109]

The HMO Problem. The HMO industry has been hailed by nationally prominent proponents of "managed competition" as the last best hope for controlling rising health care costs. But in Maryland, as in Washington State and many other states, managed care has been falling out of favor with its erstwhile political champions. Legislation targeting insurance limitations on direct access to specialists, prohibiting "gag clauses," and requiring mental health parity has been enacted already in Maryland. In light of the number of bills introduced in 1997 targeting them, HMOs will soon have to deal with additional mandated benefits and "protections for providers" in billing disputes.

House Speaker Taylor, like many politicians in other states, is planning to take a "comprehensive look" at the problems posed by managed care. Senate President Miller is expected to participate in the review, noting that "Cost is now driving everything in the health care industry." Senator Bromwell, chairman of the Senate Finance Committee, is looking into the practices of community health networks. And the controversial issue of

105.H.B. 668 was approved by a House–Senate conference committee but did not come out of committee before the Maryland legislative session ended in April 1997.

106.Rob Kaiser, M.D., "Legislators Debate Health Care Mandates," *Washington Business Journal*, February 21, 1997, p. A16.

107.American Association of Retired Persons, *Reforming the Health Care System: State Profiles 1996* (Washington, D.C.: Public Policy Institute, 1997), p. 244.

108.Martin Wasserman, Secretary of the Maryland Department of Health and Mental Hygiene, testimony before the House Economic Matters Committee, April 1996.

109."Even as Health Choice is being touted by state officials as the best way to provide medical service to the needy while keeping costs under control, those who provide this care say the 8 month old program is badly broken." Bob Keaveney, "Mistakes Plague Medicaid to Managed Care," *The Daily Record*, Vol. 214, No. 54 (March 7–13, 1998), p. 1.

subjecting HMO medical directors to a state disciplinary review is almost certain to be resurrected.[110]

In many respects, the emerging national debate about HMOs and health care quality has crystallized the internal contradictions of the employer-based health insurance market. Conflict between doctors and patients and between employers and employees is inevitable without patient choice. Managed care companies control costs by controlling the supply of medical services, establishing rules by which physicians control patient access to specialists and treatments. Although managed care firms, particularly HMOs, often argue that staff physicians are free to recommend whatever medical treatment or procedure they feel is appropriate for a patient, managed care organizations nonetheless have established mechanisms to make sure that costs do not get too high. If doctors are paid a fixed amount in their contracts and are rewarded for effectively controlling costs, they have an incentive to make sure that patients are not steered quickly to an expensive specialist. If doctors are not careful in controlling what the HMO determines to be "inappropriate or unnecessary" expenses, they may be dismissed and replaced by physicians who are better at "managing" patient care, according to what the HMO thinks is "necessary and appropriate."

The current controversy about HMOs is the widespread concern that insurance officials too often are overruling doctors on treatments they categorize as unnecessary or inappropriate.[111] Inevitably, if patients feel they are denied care, or are blocked from getting a specialized medical service, they write their state legislator and demand that the denied treatment be made legally necessary. An explosion of anti-managed care legislation in the states usually follows. A good "horror story" virtually guarantees legislative success.

Mid-Atlantic Medical Services Vice Chairman Thomas Barbera complained to state legislators in January 1997 that they are clearly confused about managed care: "If you're for us, work with us. If you're against us, put us out of business."[112] Maryland officials like squeezing the costs out of the Medicaid system, and thus have been aggressive in promoting managed care for low-income families. But they also cannot resist punishing managed care organizations with mandates, making them pay for legally required treatments, and setting the duration of patient hospital stays, all of which results in higher insurance rates.[113]

HOW LEGISLATORS CAN ACHIEVE REAL HEALTH CARE REFORM

The bureaucratic orientation of Maryland's legislators is reaffirmed by the 1998 legislative agenda. As of February 11, 1998, 85 health care (and companion) bills and 18 mental health bills had been introduced in the General Assembly. They range from legislation that would create new grievance procedures for insurance subscribers and impose new liabilities for employers and insurance plans to bills that would expand Medicaid or impose new benefit mandates. Even more revealing is H.B. 348, a proposal sponsored by Delegate Marilyn Goldwater (D-16) to amend the Constitution of Maryland to establish health care as "a fundamental right" of every Maryland citizen through a Universal Health Care Coverage Plan.[114] The result would make the state government's takeover of the health care system complete.

Among Maryland's medical professionals and business and community leaders, however, there is a growing recognition of the need to reform the

110.M. William Salganik, "Arm of Lobbyists Succeeded in Fending Off Reforms in Assembly, but Watch Out Next Year," *The Baltimore Sun*, April 13, 1997, pp. D1, D3.

111.Keilman, "Managed Care's Love-Hate Affair," p. A8.

112.*Ibid.*, p. A1.

113.*Ibid.*

114.Delegate Goldwater has 14 cosponsors for H.B. 348. The Senate companion bill is S.B. 313.

massive health care system. Serious reform will be possible only if state legislators can start to think outside of the bureaucratic box and look at every problem not through the narrow lens focused on tighter regulation, but with a broader vision of an open and expansive health care market. Policies firmly grounded in the free-market principles of real consumer choice and competition are being promoted in many states, and there is no reason why Maryland's legislators should be chained to past practices.

The momentum for serious change has begun to build. In 1996, the Maryland Hospital Association proposed merging the state's three commissions. The MHA noted that various functions are unnecessary or duplicative; policies on hospital and patient data collection are in conflict; inconsistent policies govern doctors and hospitals; and thorny questions are raised about jurisdiction. The Department of Business and Economic Development and the Maryland Economic Development Commission also have recognized the need for reform that includes both streamlining the regulatory process and reducing the costs associated with the regulatory system.

In 1997, legislators considered a bill to consolidate the three independent regulatory commissions under one large umbrella called the Office of Consumer Health Care Protection,[115] including the health care functions of the Maryland Insurance Administration and the Department of Health and Mental Hygiene. Some legislators, agency heads, and their appointees who run the current system were authorized to evaluate the bureaucracies they manage and to be involved in the development of this agency.

In the 1998 session, the House leadership introduced the Maryland Health Care Regulatory and Systems Reform Act (H.B. 2). It failed to pass. It would have consolidated the functions of the existing commissions into the HCACC. The bill would also have deleted practice parameters for doctors and eliminated the certificate of need (CON) for hospice and home health agencies. It would have retained the proposed physician payment system but would not have implemented it. As a reform measure, this bill was weak; it tinkered with the system but did little to end the regulatory suffocation burdening the Maryland health care system. Indeed, it made the HCACC into a powerful health care "super-agency."

Maryland has broad experience with the tiresome micromanagement of health care. A better plan would empower individuals and families to make health care choices that suit their own needs; would restore the independence and integrity of the medical profession; would force insurance companies to compete for consumers' dollars; and would make them directly accountable for their performance to the individuals and families they serve, rather than to corporate benefits managers or bureaucrats who think they know what is best for all their employees.

A better Maryland health care policy therefore should include provisions that:

1. Empower individuals and families. A statewide system of tax credits and vouchers for individuals and families would enable them to purchase the health insurance plans they want and need. The model for this system could be the 1992 Maryland Consumer Choice Plan initially designed by Speaker Casper Taylor and broadly supported by both Republicans and Democrats. It was comprehensive, was budget neutral, and preserved the very best elements of the health care system. Although the original bill would require significant modification, including the elimination of state mandated benefits and the addition of tax relief for both medical savings accounts and the direct purchase of medical services, it could serve as a solid starting point for serious free-market reform.
2. Refrain from expanding Medicaid but expand the availability of private insurance.

115.The Consumer Health Care Protection Act (H.B. 95) was considered by the House Committee on Economic Matters. It was reported unfavorably in 1997.

Maryland should be a leader in legislative implementation of the federal KidCare program enacted by Congress in 1997. Governor Glendening's recently enacted proposal to expand Medicaid (a welfare program) to cover children in non-welfare families with an income up to 200 percent of the federal poverty line is not the best option either for those families or for the taxpayers. Although the federal legislation enables Maryland to expand Medicaid to cover low-income uninsured children, it also allows Maryland and other states to give working families without employer-based insurance the opportunity to buy the private health plans of their choice through tax credits and vouchers.[116]

3. **Eliminate costly, duplicative, and outdated rules and regulations.** A comprehensive regulatory review of Maryland's health care system is long overdue. Rules that undermine quality care and stifle competition should be abolished. And there is no justification for retaining the counterproductive certificate of need process or regulation of hospital rates. Legislators should neither force their fellow citizens into managed care plans simply because they are bringing in a low income nor fix physician fees for thousands of medical services based on the strange economic theory embodied in Medicare's Resource-Based Relative Value Scale, which determines the economic value of a commodity by the resources required to produce it rather than the free interaction of supply and demand.

4. **Abolish the independent commissions.** If centralized planning is undesirable, then so are the institutions that would carry out its functions. That said, however, several government functions are compatible with a reformed market for health insurance. These functions—which include making consumer information available, providing comparative information on plan performance, establishing consumer protection rules for the marketing of health insurance, and setting strong fiscal solvency requirements for plans in the individual and small group markets—could fall under the Maryland Insurance Administration.

5. **Repeal costly mandated benefits and substitute solid catastrophic coverage in health insurance.** Not everyone needs or wants coverage for such things as chiropractic care or *in vitro* fertilization. But all Maryland citizens need to be assured they will not lose their home or life savings if they are hit with catastrophic illness. Legislators should realize that while coverage for various medical specialties may satisfy their lobbies, it also drives up health care costs. Higher costs make insurance less affordable for struggling families who seek only peace of mind and protection from catastrophic illness.

6. **Restore patient privacy in Maryland and shut down the costly medical care database.** Representatives of the citizens of the Free State should defend their constituents' personal right to privacy and allow them the freedom to choose a health care plan that fits their needs. A patient's private medical information does not belong to the state and certainly deserves more security than a driving record. Above all else, confidential medical information should not be transmitted to any public or private entity without a person's informed and written consent.

116. For a discussion of how to accomplish this, see Carrie J. Gavora, "KidCare Implementation: A Helpful Guide for the States," Heritage Foundation F.Y.I. No. 168, December 31, 1997.

CONCLUSION

Few Marylanders, and too few of their elected representatives in Annapolis, fully grasp the cost, complexity, and reach of Maryland's health care bureaucracy. In the five short years since the General Assembly passed the Health Care and Insurance Reform Act (H.B. 1359), Maryland has put in place a regulatory structure reminiscent of the most objectionable features of the Clinton Administration's soundly rejected Health Security Act of 1993.

State legislators should be willing to examine new approaches to reach the goal of a private-sector health care system that provides quality care for everyone. That goal can be achieved best by relying less on the strong arm of regulation and more on the free-market principles of consumer choice and competition. Doctors, hospitals, and clinical researchers should be free to use all of their expertise and to rely on the best facilities, technology, and medicine available in treating their patients. Health insurers should create plans based on flexibility and choice so that individuals and families can buy plans that best suit their particular needs, not the whims of bureaucrats and industry lobbyists. This is especially true for the self-employed. A real market based on consumer choice and competition can accomplish this goal, but imaginative and responsible political leadership is essential.

APPENDIX

A SAMPLING OF WHAT IS COVERED UNDER MARYLAND'S COMPREHENSIVE STANDARD HEALTH BENEFIT PLAN (CSHBP)[117]

Maryland's CSHBP pays benefits for covered expenses for the treatment of illness and injury up to the prevailing rate or a lower rate negotiated with providers. The prevailing rate is the rate charged by a majority of like providers for the same or similar service in the same geographic area. Benefits include:

1. Health care facility or hospital inpatient services, based on the rate approved by the Health Services Cost Review Commission.

2. Health care provider services rendered for treatment or surgery.

3. Outpatient health care facility services.

4. Office services for the treatment of illness or injury.

5. Inpatient mental health and substance abuse treatment services for a maximum of 25 days per person per year for inpatient treatment or for partial days of hospitalization treatment.

6. Outpatient mental health and substance abuse treatment services provided through the Managed Care System for Utilization Review according to a schedule of allowed benefits.

7. Detoxification services rendered in a health care facility or related institution.

8. Emergency services with a $35 co-payment that is waived if the patient is admitted to a health care facility. The co-payment and co-insurance amount apply toward the deductible and out-of-pocket limit.

9. Local professional ambulance service to and from the nearest health care facility.

10. Preventive services recommended in the U.S. Preventive Services Task Force's *Guide to Clinical Preventive Services*, and any other preventive service a federally qualified HMO is required to offer, including adult periodic health evaluations, child (through age 17) eye and ear examinations, pediatric and adult immunizations, and child wellness services. Deductibles and co-insurance are waived for child wellness services from birth to age 2, with a $10 co-payment.

11. One mammogram every other year from age 40 to 49, and one per year from age 50 and over.

12. Home care services when used as an alternative to hospitalization or inpatient treatment rendered by any other related institution.

13. Charges made by a hospice for room and board and other necessary health care services and supplies furnished in a hospice; part-time nursing care by or under the supervision of a registered nurse; home health care aide services, nutrition services, and special meals; counseling services by a licensed social worker or licensed pastoral counselor; and bereavement counseling by a licensed social worker or licensed pastoral counselor for members of the patient's family who also are insured under this plan (except that visits in excess of 15 for the family members and/or health care services beyond six months from the patient's date of death will not be considered covered medical charges).

14. Durable medical equipment including, but not limited to, prosthetic devices such as legs, arms, back, or neck braces and artificial legs,

117. Maryland Health Care Access and Cost Commission, Comprehensive Standard Health Benefit Plan, updated by various bills during the 1995, 1996, and 1997 legislative sessions.

Table 3 B 1168

Maryland's Comprehensive Standard Health Benefit Plan

CSHBP Indemnity Plan		CSHBP's Preferred Provider (PPO) Plan	
Options	**Standard Plan**	**Options**	**Standard PPO Plan**
Deductible per Year	$500 Individual $1,000 Family	**Deductible per Year** Combined in and out of network	$250 Individual $500 Family
Co-Insurance	20%	**Co-Insurance**	20% In network 40% Out of network
Out-of-Pocket Limit per Year	$3,000 Individual $6,000 Family	**Out-of-Pocket Limit per Year** Combined in and out of network; includes deductible	$2,500 Individual $5,000 Family
Lifetime Maximum per Person	$1 million	**Lifetime Maximum per Person**	$1 million

Source: Maryland Health Care Access and Cost Commission's Comprehensive Standard Health Benefit Plan, updated during 1995, 1996 and 1997 legislative sessions by various bills.

arms, or eyes, and the training necessary to use these prostheses.

15. Outpatient laboratory and diagnostic services for a $20 co-payment or the co-insurance percentage, whichever is greater, but not to exceed the actual charge.

16. Outpatient rehabilitative services rendered by a licensed health care provider or by a licensed physical therapist, occupational therapist, or speech therapist to restore function lost due to an illness or injury. Such benefits will be provided for a maximum of 60 calendar days of treatment per condition per year for allowable charges according to a schedule of benefits.

17. Up to 20 chiropractic visits per condition per year; additional services may be approved through a case management program for high-cost cases according to a schedule of benefits.

18. Health care services in a skilled nursing facility as an alternative to medically necessary inpatient health care facility services for a maximum of 100 days per year, subject to a $20 per day co-payment or the co-insurance percentage, whichever is greater, but not exceeding the actual charge.

19. Infertility services, except those services specifically excluded. Covered medical charges incurred after the diagnosis of infertility has been confirmed will be paid at 50 percent.

20. Charges incurred in connection with nutritional services, six visits per year per condition for the treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease.

21. Charges incurred in connection with autologous and non-autologous bone marrow transplants, cornea, kidney, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants.

22. Medical food when ordered by a health care provider qualified to provide diagnosis and treatment in the field of metabolic disorders.

23. Family planning services including counseling, the implanting and fitting of birth control devices and follow-up visits, and voluntary sterilization. The cost of the birth control devices is not covered.

24. Except for rehabilitative services provided in early intervention and school services, covered medical charges include rehabilitative services for children through 19 years of age for the treatment of congenital or genetic birth defects, including services for cleft lip and cleft palate, orthodontics, oral surgery, and otologic, audiological, speech, physical, and occupational therapy.

25. All cost recovery expenses for blood, red blood cells, platelets, plasma, immunoglobins, and albumin.

26. Pregnancy service, including abortion.

27. Generic prescription drugs, including birth control pills, Norplant and Depo Provera (or their generic equivalent), and insulin.

28. Controlled clinical trials—treatment that is approved by an Institutional Review Board; conducted for the primary purpose of determining whether a particular treatment is safe and efficacious; approved by an institute or center of the National Institutes of Health, Food and Drug Administration, the Department of Veterans Affairs, or the Department of Defense.

29. Other health care services approved by the case management program.