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ANALYSIS OF PROPOSED HEALTH CARE REFORMS IN MARYLAND

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INTRODUCTION

THE ISSUES OF EXTENDING health insurance coverage and lowering the expense of health insurance have received significant attention this year. While politicians debate federal legislation that attempts to address these issues, there is also movement at the state level to do the same. One group in Maryland, the Maryland Citizens Health Initiative Education Foundation (MCHI), previously succeeded in convincing legislators to adopt its health care plans. MCHI successfully pushed for legislation that penalized Wal-Mart for not spending a certain portion of its revenue on health care (although this was later overturned) and was successful in its calls to expand state Medicaid and Maryland Children's Health Insurance Program.

MCHI is now proposing a complex initiative that would mandate almost all Marylanders to have health insurance, expand Medicaid, create a state-run health insurance purchasing pool, create a state-run reinsurance program, and other measures to both reduce the number of Marylanders without insurance as well as decrease the cost of insurance. However, this plan would necessitate a huge increase in Marylanders' taxes and would be unlikely to achieve the sweeping goals MCHI sets. In fact, the plan would increase taxes for Marylanders and would also likely increase health insurance premiums.

PLAN DETAILS

The MCHI plan is complex one and contains many different proposals. It would be funded by raising taxes on alcohol and cigarettes and a 2 percent payroll tax for all employees in the state. Some of the plan's main provisions are:¹

Health Insurance Pool. The individual and small group health insurance markets (where individuals and small businesses buy their health insurance policies) would be combined into one pool. Employers with fewer than 100 employees and individuals would be forced to buy coverage in this pool and subsidies would be provided to individuals with incomes below 400 percent of the federal poverty level (FPL).

Individual Mandate. Almost everyone without insurance in Maryland would pay a penalty to the government. Those excepted from these penalties would be eligible for Medicaid but not yet enrolled in the program, and those without access to affordable health insurance, as determined by the government.

Catastrophic Reinsurance Plan. The state would establish a reinsurance program to replace the private reinsurance plans insurers in the state currently use to protect themselves against covering high-cost individuals.

Expanding Medicaid. The state's Medicaid program would be expanded to cover non-parent adults who earn up to 200 percent FPL and parents who earn up to 300 percent of FPL. The services offered by Medicaid would be increased to include dental services, residential alcohol and drug treatment, and HIV counseling and testing.

Maryland Institute for Clinical Value. This institute would focus on reducing spending on wasteful health care and promoting spending on high-value care. The institute would be appointed by the governor and would issue

binding recommendations to insurance companies regarding practices they can cover. The institute would also set insurance plans' cost-sharing policies.

EFFECTS OF THE PLAN

Hurting Consumers. While this plan's intention is to help health insurance consumers, it would actually have the opposite effect by increasing the price for health insurance and reducing choice for many consumers.

The health insurance pool and individual mandate of this legislation is very similar to what has been tried in Massachusetts, with its health insurance connector and individual mandate. In Massachusetts, this health care legislation has resulted in a variety of negative consequences. For instance, only certain types of health insurance would allow a Massachusetts resident to satisfy the state mandate. As Cato Institute analyst Michael Tanner points out in his critique of the Massachusetts plan:

To qualify under the mandate, the [government] has decreed that insurance must now (1) include prescription drug coverage; (2) cover preventive care services; (3) have a deductible of no more than \$2,000 for individuals or \$4,000 for families, with drug deductibles of no more than \$250 for individuals and \$500 for families; (4) have an in-network out-of-pocket maximum (including deductibles, co-payments, and coinsurance) of no more than \$5,000 for individuals and \$10,000 for families; and (5) have no limit on annual or per sickness benefits.²

These rules do not apply just to the previously uninsured. Individuals who already had health insurance, but whose insurance did not meet these requirements, were required to give up their current insurance and purchase insurance that conformed to the new rules. However, the state postponed the application of the requirements for those who currently have noncomplying insurance until January 1, 2009, meaning that we do not yet have information on how many Massachusetts residents were required to switch plans.

Clearly Maryland would not avoid these same problems. The state has already imposed a variety of mandates on insurance in the individual and small group market that have raised its cost. There are currently 66 mandated services, from in-vitro fertilization to minimum hospital stays for testicular cancer treatments to the services of chiropractors and acupuncturists. Every insurance policy sold in the individual or small group market must include these services, even if the purchaser has little need or desire for them.

Furthermore, the legislation proposing a health insurance pool mandates that any health insurer who sells insurance in the state cannot turn down anyone who wants to buy it, cannot price the insurance based on the purchaser's medical history, and cannot refuse to renew that insurance policy. These policies are intended to ensure that insurance

companies cannot refuse to sell insurance to those with expensive medical conditions or charge those same people more for their insurance. These limitations resemble current Maryland law.

MCHI claims that health insurance rates would be lowered because this reinsurance plan may help to spur competition in the state's health insurance marketplace.

The state's current restrictions and mandates, which this proposal would not change, have contributed to the high cost of insurance in Maryland as well as the absence of competition. These mandates and restrictions prevent insurers from tailoring policies to fit the needs of their customers. They also prevent insurers from pricing their products in a way that will accurately reflect their risk. Consequently, the prices of all policies are higher than they would be without restrictions.

MCHI, however, claims that their plan will actually lower prices for insurance in the state. They assume that the plan will lower insurance companies' administrative costs by 10 percent and that a state-run reinsurance plan will further lower the cost by 15 percent, which would result in a 25 percent cut in premiums.

While these assumptions are little more than wishful thinking, even if insurance companies' costs did decline by 25 percent, those purchasing insurance from them would not see their premiums decline by that much. In a market with little competition (such as Maryland's individual and small group health insurance markets), reduced costs are likely to create higher profits for companies, not lower prices for consumers. Only competition will result in these lower costs being passed along to consumers. Nothing in the MCHI plan would lead to more competition in the individual or small group market. In fact, we may even see less competition given the new rules and regulations that will likely be placed on insurance under this plan (see below).

To achieve the savings from lower administrative overhead the MCHI plan anticipates, insurers operating in the "pool" would need to lower their overhead by between half or two-thirds of their current overhead, according to MCHI's numbers. The only rationale given is that "greater efficiency" will be at work in this pool and the lower administrative overhead number is close to the administrative overhead in large group insurance. While this type of efficiency could occur, it could just as likely not occur or be far less than MCHI projects. These numbers appear to result from an optimistic guess rather than a rigorous economic analysis.

Another part of the plan that is designed to reduce costs, the state reinsurance pool, will likely create less competition in the state's insurance market, meaning any cost savings will not be passed along to consumers. As the American Academy of Actuaries notes in a critique of a proposed federal government reinsurance plan:

*If reimbursement is based on actual amounts paid by insurers and self-funded plans, the payers probably would alter certain behaviors (e.g., provider contracts, cost-saving measures) as they will no longer be responsible for the catastrophic costs associated with individuals or groups covered by reinsurance.*³

That is, once the government is running a reinsurance program, those buying this insurance would have less incentive to try and control costs. In order for the state to control the burden of the reinsurance program, regulations and restrictions on insurance companies would inevitably be imposed. Furthermore, there is no indication that competition is lacking in the current reinsurance market, rates are unreasonable, or reinsurance is difficult to obtain. In short, the market is working fine and there is no rationale for the government to become involved.

Interestingly, MCHI touts a reduction in competition as the way this plan would save money. Two companies would provide reinsurance for the state under the rationale that “consolidation and uniformity of a comprehensive reinsurance plan”⁴ would improve the delivery of health care in the state. Yet, two paragraphs later, MCHI claims that health insurance rates would be lowered because this reinsurance plan may help to spur competition in the state's health insurance marketplace.

MCHI seems to be picking and choosing economic models to obtain its desired result. In the first instance, reducing competition and imposing “consolidation and uniformity” will improve care and reduce costs. In the second, competition reduces costs. MCHI needs to decide how the cost savings will be passed along to consumers. As the state's experience illustrates, with two health insurance companies providing around 90 percent of the policies in the individual and small group market, when two companies control the market, prices are not competitive. The same factors will operate in the reinsurance market if the MCHI plan is enacted.

MARYLAND INSTITUTE FOR CLINICAL VALUE

The Maryland Institute for Clinical Value also has the potential to harm health care consumers. This institute would evaluate medical treatments in an attempt to determine which ones offer value, on both a cost and clinical basis. That is, it would determine which medical procedures would benefit patients and in a cost-effective way. The institute's goals appear sound theory. Who can oppose ensuring patients receive the best value in their health care services? Yet such government ventures are fraught with

practical problems. Determining what medical services are clinically effective may not be as easy as MCHI seems to think. As Dr. Jerome Groopman and Dr. Pamela Hartzband noted in *The Wall Street Journal*:

Data from clinical studies provide averages from populations and may not apply to individual patients. Clinical studies routinely exclude patients with more than one medical condition and often the elderly or people on multiple medications. Conclusions about what works and what doesn't work change much too quickly for policy makers to dictate clinical practice.

An analysis from the Ottawa Health Research Institute published in the *Annals of Internal Medicine* in 2007 reveals how quickly conclusions derived from clinical studies about drugs, devices and procedures become outdated. Within one year, 15 of 100 recommendations based on the “best evidence” had to be significantly reversed; within two years, 23 were reversed, and at 5 1/2 years, half were contradicted. Americans have witnessed these reversals firsthand as firm “expert” recommendations about the benefits of estrogen replacement therapy for postmenopausal women, low fat diets for obesity, and tight control of blood sugar were overturned.⁵

The issue of cost-effectiveness is an even more troubling aspect of this plan. Some medicine and treatments provide benefits but at very high monetary costs. This plan would weigh the cost of such treatments and medicine against the benefits they provide. The institute would have the authority to demand insurance companies and health care providers in Maryland follow its recommendations. In other words, unless the institute approved coverage, your insurance would be forbidden to pay for it.

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While this type of institute is established with legislative language that would seem to put science and efficiency first, this has not been the case with other institutions established by governments. Oregon, for instance, has a similar panel for its Oregon Health Plan. As Michael J. Astrue noted in *Issues in Law and Medicine*:

The most controversial feature of the 1991 proposal was the list of conditions and treatments ranked from most important to least important. Oregon proposed to fund treatment for only 587 of 709 categories. Thus Oregon would have denied coverage for treatment needed by persons with a diverse group of medical problems, includ-

ing disk disorders, viral hepatitis, chronic bronchitis, cancer where treatment would not result in a ten percent chance of survival for five years, the common cold, and the later stages of AIDS.

Oregon went through an elaborate multi-year process to develop these rankings. Many associated with the process took great pride in it and held it up as a model for the rest of the country. In my view, those associated with the process tried to sell it politically by persuading people that they had established a fair and scientific methodology that justified results that seemed harsh.

Nothing could be more untrue, since the rankings were substantially the result of highly discretionary and unscientific judgments by a small group of people. This fact became patently clear when I asked Oregon to explain the weight given to so-called quality of life measures in the process, and state officials could not do it.

Peculiar results abounded in the rankings. As one commentator has noted, surgical treatment for ectopic pregnancies and appendicitis were rated as less important than dental caps for “pulp or near pulp exposure” and splints for temporomandibular joint disorder, even though treatments for the first two procedures are virtually 100 percent effective in treating otherwise generally fatal conditions, while the latter conditions are minor and may correct themselves without any treatment at all.⁶

Analyst Linda Gorman noted that politics, not science, seems to drive much of the Oregon panel’s decisions:

Between 2002 and 2009 there was a fairly radical reordering of priorities. A great many lifesaving procedures that ranked high in 2002 have been relegated to much lower positions in 2009, while procedures only tangentially related to life and death have climbed to the top.

In 2002 there was far more emphasis on actual medical care and measurable interventions that save lives and improve individual functioning. Various interest groups have spent the past seven years reordering the political priorities embodied in the list.⁷

Giving this government panel the power to demand insurance companies not pay for certain procedures will likely lead to a substantial reduction in state residents’ quality of health care.

PUTTING MARYLAND AT AN ECONOMIC DISADVANTAGE

MCHI’s plans are sure to hurt health care consumers, business owners, and employees in Maryland.

Payroll Tax. The biggest hit businesses would take under this bill comes from the 2 percent payroll tax. Maryland businesses already pay an 8.25 percent tax on all corporate profits, the fifteenth-highest in the nation according to the Tax Foundation. Overall, the Tax Foundation rates forty-

four other states’ business tax climates ahead of Maryland’s. The imposition of this 2 percent payroll tax would certainly make Maryland an even less attractive place for business.

Unlike a corporate income tax, a payroll tax must be paid regardless if a business makes a profit. Every business in the state, even those losing money, will pay the tax on every employee it hires. This tax is cost-prohibitive for businesses to open in this state. In some areas of the state, such as western Maryland, the Eastern Shore, and communities close to the Virginia and Pennsylvania state line, this payroll tax will likely drive some potential business owners

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across state lines where they can still access Maryland markets but will not be forced to pay the punitive tax.

This payroll tax will also hurt employees by slowing hiring and reducing wages. When a business owner considers hiring a new employee, the cost of that employee is more than just the employee’s wages. The business owner also considers the employee’s benefits, federal payroll taxes, unemployment insurance, and administrative costs of that new employee. By increasing the cost of every new employee, a business owner will lower wages to compensate for the added expense of the payroll tax.

For instance, if it costs \$70,000 for a business owner to hire a new employee, it does not mean the employee will make \$70,000. In fact, the employee’s salary may only be \$50,000, with the other \$20,000 consisting of benefits, payroll taxes, and the like. If Maryland imposes an additional 2 percent payroll tax, the employee’s salary will be reduced by \$1,000.

At the lower wage range, where business owners are legally forbidden from lowering wages beyond the state and federal minimum wage laws, it will be unaffordable for a business owner to hire an employee. That shift will increase unemployment among low-wage workers.

MCHI claims that although this plan would impose a new payroll tax, businesses would actually see their payroll costs decrease because the enactment of this plan would lead to lower health insurance premiums. This contention, of course, ignores the cost to the many businesses in the state that do not currently offer health insurance benefits. Also, since the lower insurance costs, if they materialize, would only accrue to businesses that purchase their insurance through the new insurance pool, those businesses with more than 100 employees (which are ineligible to purchase insurance through the pool) and those that self-insure (that is, provide their own insurance coverage

TABLE 1 OTHER TAXES

STATE	TAX PER GALLON OF DISTILLED SPIRITS	TAX PER GALLON OF WINE	TAX PER GALLON OF BEER	TAX PER PACK OF CIGARETTES
MARYLAND	\$10.03	\$2.96	\$1.16	\$3.025
DELAWARE	\$5.46	\$.97	\$.16	\$1.15
VIRGINIA	\$19.00	\$1.51	\$.2565	\$.30
PENNSYLVANIA	\$6.65	N/A	\$.08	\$1.35
DISTRICT OF COLUMBIA	\$1.50	\$.30	\$.90	\$2.50
WEST VIRGINIA	\$2.05	\$1.00	\$.18	\$.55

instead of buying policies from an insurance company) would not see any savings.

According to the Maryland Health Insurance Commission, only 39.6 percent of small businesses in the state partake in the state's small group market.⁹ Only these businesses could possibly receive any benefits, if they materialize, from MCHI's plan. Business owners and their employees would be penalized by this new payroll tax with no possibility of receiving any benefit.

Many businesses in the small group market would certainly take a hit under this plan. For instance, roughly 15,000 businesses offer high-deductible insurance plans in conjunction with health savings accounts.¹⁰ These businesses would almost certainly see their costs rise. The MHIP Board's requirement of a certain minimum standard would likely either end or severely restrict these policies. In fact, it would be illegal to subject certain aspects of treatment (such as "cost-effective preventive care and chronic disease management services") to high deductibles. By law these services would be subject to "small copayments."¹¹

By increasing the tax on a pack of cigarettes ... businesses in Maryland would also see their out-of-state competitors have a distinct advantage.

Such requirements will end up raising the cost of health insurance policies, not lowering them. Those who buy high-deductible insurance do so because the tradeoff for the high deductible is a lower premium. Limiting deductibles or forcing certain services to be subject to small copayments will raise the amount of the premium.

Businesses that do not contribute towards health insurance for their employees and businesses that offer high-deductible plans will see an increase in their costs. Also likely, most (if not all) Maryland businesses would pay more for insurance under this plan than they would otherwise. The same factors of this plan that would raise the price for

individuals to purchase insurance would also raise the price for businesses to purchase insurance. Furthermore, the savings that MCHI claims will result from this plan are unlikely to materialize. In the end, if this plan is enacted, business owners will certainly see their tax burden increase and will likely see the cost of their insurance premiums increase, too.

Other Taxes. Besides the imposition of the payroll tax, the other tax increases in this bill will hurt both consumers and businesses in Maryland. By increasing the state's alcohol tax to \$10.03 per gallon for distilled spirits, \$2.96 per gallon of wine, and \$1.16 per gallon of beer, this plan would severely disadvantage Maryland businesses serving or selling alcohol that face out-of-state competitors. Likewise, by increasing the tax on a pack of cigarettes to \$2.75 and then to \$3.025, businesses in Maryland would also see their out-of-state competitors have a distinct advantage, see Table 1, above.

In a state like Maryland, whose geographic shape and workforce trends allow residents to easily shop in other states, these high taxes would certainly create a loss for many business owners.

The many residents of Montgomery, Prince George's, and Charles counties who work in Washington, D.C. can easily pick up a lower-priced pack of cigarettes or a bottle of wine before their commute home. On the Eastern Shore, where Delaware already lures many with its lack of sales tax, it would be easy to travel a few miles to save big on cigarette and alcohol purchases. Marylanders who live in areas close to Pennsylvania, Virginia, and West Virginia would also face a similar temptation.

BUSTING THE BUDGET

Medicaid expansion is especially likely to strain state budgets. This plan would expand Medicaid to adults living in families that make up to 300 percent of the federal poverty level if these families have a dependent child (children up to this level are already covered by the Maryland Children's Health Insurance Program). For adults in families without a dependent child, they would receive Medicaid if their income is at or below 200 percent of the federal poverty level.

The Maryland Department of Legislative Services estimates the total cost of this expansion would have been \$666.9 million in FY2010. The federal government's Medicaid matching rate is traditionally 50 percent, although this has been temporarily raised. However, this temporary increase is not permanent and it seems likely that if this legislation were enacted, the state's share of funding this Medicaid increase would be at least \$333.45 million in the first year.

As this Legislative Services estimate was for FY2010, if this bill were enacted next year, this amount would certainly be higher with projected cost increases in future years. We can also assume that this cost will be higher than anticipated due to the inability to accurately predict Medicaid expenditures, especially during times of weak economic performance. For instance, in the first year of the state's expansion of Medicaid benefits to more adults, the program's cost exceeded expectations by \$50 million.¹² Medicaid costs exceeding projections is common in the program.¹³

Another potential problem of this bill is the subsidies to purchase insurance it authorizes for families with incomes up to 400 percent of the federal poverty guidelines. For those with incomes up to 300 percent of FPG, the state would pay 50 percent of the average premium for the enrollee's age in a "typical" plan. For those with incomes between 301 percent and 400 percent, the state would pay 25 percent of the average premium for an enrollee's age for a "basic" plan. This aspect of the plan also imposes a large burden on the state budget, which will grow only larger as the cost of health insurance premiums increase.

A BETTER WAY TO INCREASE ACCESS AND LOWER COST

While the MCHI plan will likely do little to help improve access to health care in the state (and will likely harm access for many), policymakers could take steps to lower the cost of health care in Maryland and increase Marylanders' access to health care. Since the state faces significant budget problems, policymakers should focus on ways to help Marylanders afford health care and health insurance without further burdening state taxpayers. The General Assembly could take a few simple steps that would result in large savings for Marylanders:

Remove Barriers to Competition. The view that competition in the health care marketplace leads to lower prices has been embraced by people as dissimilar as Milton Friedman and Barack Obama. Unfortunately, there is little evidence this view prevails in Annapolis. Instead, legislators have erected numerous barriers to competition among health care providers, leading to lower quality care and higher prices. Dismantling these barriers would help Maryland consumers and cost taxpayers nothing, unlike the reforms urged by MCHI.

Scope-of-practice laws thwart competition. These laws have been put in place at the request of doctors and other health care professionals who do not wish to allow patients to choose lower-price alternatives. Many medical procedures, for instance, could be performed by nurse practitioners. Eleven states allow nurse practitioners to practice without the involvement of a medical doctor. They also allow them to write prescriptions.¹⁴ Maryland lawmakers, however, have defeated attempts to allow nurse practitioners more freedom. Likewise, dental hygienists are also

Other states do not mandate the services Maryland mandates, and yet consumers in those states are still able to find policies that cover them, if the consumer wishes.

restricted by state law from undertaking many activities that are legal in other states.

Another barrier to competition that restricts patient choice and drives up health care costs is the state's certificate of need (CON) law. Under the CON law, any new health care facility must seek approval from the government to open. This law's protectionist intent is quite explicit. One of its rationales is to ensure a proposed facility "will not have a significant negative impact on the cost, quality, or viability of other health care facilities and services."¹⁵

These laws have the effect of artificially restricting the supply of health care providers in Maryland. That, in turn, drives up the cost of health care in the state and leads to less access to care, especially in rural areas.¹⁶

Eliminating the CON law and liberalizing the scope-of-practice laws would allow Marylanders more choice in meeting their health care needs at lower costs.

Remove or Ease State Health Insurance Mandates.

Any insurer wishing to sell a health insurance policy in Maryland to individuals or any business that does not self-insure must meet certain mandates and regulations placed on them by the government of Maryland. These regulations and mandates drive up the cost of insurance and drive insurers out of the market. Easing these mandates (and removing many entirely) would help lower prices for Maryland consumers both by reducing insurers' cost of doing business in the state and by allowing greater competition for consumers' business.

Maryland has more state mandates than almost every other state. Insurance sold in the state must cover 66 different procedures that were imposed by legislators (with the approval of the governor).¹⁷ These procedures are mandatory for every insurance policy. Even if you do not want

insurance to cover acupuncture or chiropractic services, or chlamydia testing or in-vitro fertilization, it is illegal to sell you a policy that does not cover them.

Some who defend mandates claim that without these government rules, insurance companies would not offer such services. That is simply untrue. Other states do not mandate the services Maryland mandates, and yet consumers in those states are still able to find policies that cover them, if the consumer wishes. Mandates simply force consumers to buy policies that cover services politicians (and health care lobbyists) want people to have, not what consumers desire.

The state also puts caps on co-payments and deductibles for policies that are sold to small businesses in the state.¹⁸ This, too, raises prices for insurance. If a business can only afford to buy a policy for its employees that offers coverage but has an out-of-pocket limit for individuals of \$5,000, the business cannot do it. That leads to businesses simply forgoing insurance because they cannot afford the type of policies allowed by Maryland law.

CONCLUSION

Although the General Assembly and Governor O'Malley raised taxes in 2007, the state still faces a large budget deficit. MCHI's plan would increase state spending even more and add a host of new taxes on Maryland's businesses and residents. Its effects on the affordability of health insurance would likely be minimal. In fact, the plan would likely raise the health insurance rates for many in the state.

Reducing the restrictions on insurance policies, allowing a wider range of health care professionals to provide more treatments, and eliminating the Certificate of Need law would help to bring down the price of health care and health insurance in Maryland without costing taxpayers a dime. As the state faces a large deficit, many busi-

nesses struggle to stay open, and taxpayers adjust to the higher tax rates imposed by the 2007 special session of the General Assembly, this is the type of health care reform the state needs today.

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14. For a more complete list of the restrictions on nurse practitioners by state, see the "Chart Overview of Nurse Practitioner Scopes of Practice in the United States," at <http://www.health.state.mn.us/healthreform/workforce/npcomparison.pdf>.
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16. Various studies have found that CON laws increase health care costs. See, for instance the testimony of Mark J. Botti, Chief of the Litigation Section of the Department of Justice's Antitrust Division, before a Georgia legislative committee at http://www.healthwatchusa.org/downloads/CON_Folder/20070223-CON-Competition-Healthcare-Botti.pdf.
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