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COVERING THE UNINSURED IN MARYLAND: FUTILE GESTURES OR REAL REFORMS?

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BACKGROUND

The debate over extending health insurance coverage to the uninsured is again a major issue in the 2006 session of the Maryland General Assembly. During the 2005 session, the General Assembly passed the Fair Share Health Care Fund Act, which Governor Robert Ehrlich subsequently vetoed.[1] The act was quickly dubbed "the Wal-Mart Bill" because that company is the principle target of the legislation's sponsors and supporters. The bill's supporters then persuaded the General Assembly to override the Governor's veto during the opening days of the 2006 session.

The legislation requires private employers in Maryland with 10,000 or more employees to either pay 8 percent of their total payroll for worker health insurance (6 percent in the case of non-profit employers), or pay the difference to the state in a tax. Any tax receipts are dedicated to funding the state's Medicaid program.

On the surface, the debate over the Fair Share Act was ostensibly a debate over the problem of the uninsured in Maryland. But in reality it represented a triumph of the politics of symbolism over the politics of substantive reform.

The Fair Share Act is nothing more than a futile gesture of political symbolism destined to have no meaningful effect on health insurance coverage. That reality is made readily apparent when the legislation's provisions are compared to published data on the uninsured in Maryland. However, such an analysis also indicates the scope for truly innovative approaches that could indeed expand coverage to many of those who currently go without health insurance, should Maryland's elected officials now choose to set aside symbolic politics in favor of getting serious about enacting genuine health care reforms.

WHY THE UNINSURED LACK COVERAGE

As in every other state, Maryland lawmakers periodically attempt to address the problem of a lack of health insurance coverage among a significant share of the state's population. While it is true that Maryland has a lower rate of uninsurance than the national average (15 percent in Maryland versus 17 percent nationally), that difference is actually attributable to Maryland's more favorable economic conditions, rather than to any superior policy solutions enacted by the state government.

A key factor in Maryland is the disproportionate share of federal government workers in the state. Nationwide, the federal workforce accounts for 2 percent of all non-elderly adults, while in Maryland

1. The enrolled bill as passed can be found at http://mlis.state.md.us/2005rs/bills/hb/hb1284e.pdf.

it accounts for 8 percent. Thus, even though Maryland has a somewhat lower rate of private sector employment (65 percent of non-elderly adults versus a national average of 68 percent) and the same average share of state and local workers (10 percent of adults), the disproportionate size of the federal government workforce in Maryland nudges the state's non-elderly adult employment rate up to 83 percent, or three percentage points above the national average of 80 percent. [2]

The state's higher employment rate also translates into a higher rate of employer- sponsored insurance coverage among Marylanders. In Maryland, 71 percent of the non-elderly population is covered by employer-sponsored health insurance, while the U.S. average is 63 percent. In addition, Maryland has the 13th lowest poverty rate (10 percent), the fifth highest per capita income ($39,629), and the third highest median household income ($56,763) among all states.[3]

The question then is, given Maryland's relatively superior economic conditions, why do a significant number of its residents still lack health insurance coverage? Answering that question first requires understanding the basic factors that contribute to uninsurance and then analyzing the data on Maryland health care coverage in light of those factors.

In the case of any given uninsured person, the lack of coverage can be attributed to one or more of the following three basic factors:

1. **Affordability.** Some of the uninsured simply do not have sufficient incomes to pay for coverage. Furthermore, even if coverage could be made less expensive than it currently is, many of those individuals would still be unable to afford health insurance absent additional assistance in the form of some kind of public subsidy. The biggest public policy issue in this regard is the current binary, or 'all or nothing,' structure of publicly funded health coverage programs, namely Medicaid in the case of states. Those who qualify get full coverage, while those who do not qualify get nothing. In reality, some individuals with incomes just under Medicaid eligibility thresholds could probably afford to contribute something towards their coverage, while many of those just above the eligibility thresholds will certainly need some subsidy to afford health insurance.

2. **Availability.** For other uninsured individuals, the issue is as much or more of availability as it is of affordability. In general, these are persons who lack access to employer-provided insurance. For many of them the availability problem quickly translates into an affordability issue. That is because the current system of federal tax subsidies for employer-sponsored coverage, combined with state insurance laws that divide the market into small-group, large-group, and non-group segments, each with different regulations, make employer-group insurance significantly less expensive than the alternative of non-group insurance. Importantly, however, non-group insurance does offer the advantage of coverage portability, while employer-group insurance is never truly portable. Thus, were governments to equalize the costs of employer-group insurance versus non-group insurance through public policy changes, the purchase of non-group insurance would likely become the preferred solution for many individuals, particularly those who change jobs more frequently.

3. **Value.** Finally, the principle issue for some of the uninsured is one of value. These individuals have access to coverage and can afford to pay for it, but still decline to purchase health insurance (either group or non-group) because they perceive it to have low value for the price charged (premium). This perception of health insurance as a 'poor value for money' can result from several factors, including:

    - Community rating practices that make coverage more expensive for younger and better risk individuals

2. Maryland Health Care Commission, "Health Insurance Coverage In Maryland Through 2003," November 2004, at http://mhcc.maryland.gov/health_care_expenditures/insurance_coverage/healthinsrpt112404.pdf

3. Poverty rate data from Kaiser Family Foundation, State Health Facts, "Household Income, 2004," at www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi, per capita income data extracted from U.S. Department of Commerce, Bureau of Economic Analysis, Regional Economic Accounts at www.bea.doc.gov/bea/regional/spi/, median household income from U.S. Census Bureau, "Three-Year-Average Median Household Income by State: 2002-2004," at www.census.gov/hhes/www/income/income04/statemhi.html

- Regulations that prevent the offering of less comprehensive, and thus less expensive, plans
- A system of public subsidies for uncompensated care that perversely encourage the healthy uninsured to go without coverage, knowing that someone else will pay for their treatment should they in fact happen to need care
- A general market structure that results in the offering of plans that focus on near-term protection at the expense of long-term protection, such as by applying underwriting in the non-group market equally to those with and without continuous, prior coverage.

Given the interaction of these three basic factors, it is not possible to simply subdivide the uninsured into three groups. Rather, the reality for any given uninsured individual is that one of these three factors is the dominant reason for a lack of coverage while one, or both, of the remaining factors also influence the coverage decision.

However, this analysis is useful in suggesting a three-prong approach that policymakers can take to measurably expand health insurance coverage. The most promising strategy is to systematically address the three basic factors that produce uninsurance with three complementary sets of reforms:

Set One: Undertake reforms designed to moderate the cost of coverage in general and to permit health insurance markets to better align premiums with perceived value.

Set Two: Institute reforms in the ways that health insurance is bought and sold to make coverage more accessible and available, particularly for those whose employment patterns do not match the premise of long-term employment at a large firm offering employer-group coverage that underlies the current market structure.

Set Three: Reform public programs to provide subsidies to more individuals, but scale them according to income and need. Also, convert existing subsidies for uncompensated care currently directed to medical providers into coverage subsidies directed to individuals.

THE UNINSURED IN MARYLAND

Some 740,000 uninsured persons are estimated to live in Maryland. Table 1 shows the distribution of the Maryland uninsured by family income. Just over one-third (33.78 percent) of the uninsured have incomes in excess of 300 percent of the Federal Poverty Level.[4]

Thus, it can be presumed that for about two-thirds of the uninsured (those with incomes below 300 percent of FPL) the principal issue is one of affordability. However, for those with incomes in the 200 to 300 percent of FPL range, a significant share of the presumed affordability problem may actually be an indirect effect of availability issues. For example, their employment patterns may exclude them from access to employer-group insurance, leaving them only the option of the currently more expensive non-group insurance market. Also, for some share of this group, value is probably an issue as well. Specifically, those who are young, healthy and without dependants may not perceive the coverage offered them to be worth the cost.

Table 1: Maryland Uninsured by Family Income, in 2003

Income in Dollars and as Percent of Poverty Level	Number	Percent of Total
Poor (<=$14,810) (<=100%)	150,000	20.27%
Near Poor ($14,810 - $29,620) (101% to 200%)	210,000	28.38%
Low Moderate ($29,620- $44,430) (201% to 300%)	130,000	17.57%
Mid Moderate ($44,430 -$59,240) (301% to 400%)	80,000	10.81%
High Moderate ($59,240 - $88,860) (401% to 600%)	90,000	12.16%
High ($88,860+) (601%+)	80,000	10.81%
TOTAL	740,000	100.00%

4. Data in Tables 1 through 7 taken from Maryland Health Care Commission, "Health Insurance Coverage In Maryland Through 2003," November 2004.

For the one-third with incomes above 300 percent of FPL, the principal issues are likely to be availability and value for money, rather than affordability *per se*. That conclusion is strongly suggested by the data in Table 2 which shows the distribution of Maryland uninsured, but in this case is grouped into four categories by the dollar value of family income, and also broken-out by adults and children. The presence of 230,000 uninsured (including 50,000 children) with annual family incomes in excess of $50,000, and the fact that 100,000 of those have annual family incomes of more than $90,000, is evidence for this conclusion.

Table 2: Maryland Uninsured Adults and Children by Family Income, in 2003

Annual Family Income	Adults	Children	Total
up to $25,573	260,000	50,000	310,000
$25,574 - $51,145	160,000	40,000	200,000
$51,146 - $90,018	100,000	30,000	130,000
$90,019+	80,000	20,000	100,000
TOTAL	600,000	140,000	740,000

Contrary to common perceptions, most of the uninsured have some connection to the workforce. As can be seen in Table 3, almost three-quarters (74.3 percent), or 550,000 of the uninsured live in families with one or more full-time workers. Only 90,000 (12.16 percent) are in families with no workers. Thus, it is reasonable to infer that there is something about the current structure of the employer-provided insurance system that makes it an inadequate coverage solution for those workers. A closer look at the data suggests that this is indeed the case.

Table 3: Maryland Uninsured by Family Work Status, in 2003

Family Work Status	Number	Percent of Total
3+ Full-time, Full-year	40,000	5.41%
2 Full-time, Full-year	150,000	20.27%
1 Full-time, Full-year	360,000	48.65%
Only Part-time (<35hrs/wk)	30,000	4.05%
Only Part-year (<50wk/yr)	70,000	9.46%
Non-workers	90,000	12.16%
TOTAL	740,000	100.00%

To start with, four-fifths of the uninsured are adults, accounting for 600,000 of the total uninsured population of 740,000. Table 4 shows that three-quarters of those adults, or 450,000 of the 600,000 are workers. As might be expected, most of those uninsured workers have low earnings. Indeed, as Table 4 also shows, more than half (250,000 or 56 percent) earn only $20,000 or less a year.

But stopping at this point in the analysis would lead to the incomplete and misleading conclusion that the phenomenon of uninsured workers is principally an issue of low-wage employees and part-time workers. In fact, that is only partially true. The more accurate description of reality is that many uninsured adult workers with low earnings are actually secondary workers in families with a primary worker who earns more, and thus have a total family income that is more comfortably middle-class.

Table 4: Uninsured Adult Workers in Maryland by Workers Income, in 2003

Workers Annual Income	Number	Percent of Total
up to $20,000	250,000	55.55%
$20,001 - $35,802	120,000	26.66%
$35,803 - $59,623	60,000	13.33%
$59,624 or more	20,000	4.44%
TOTAL	450,000	100.00%

It is of considerable significance that the disproportionate share of uninsured workers with low earnings does not translate into a disproportionate share of the uninsured having low family incomes. This can be seen from the data in Table 5, which disaggregates uninsured adult workers by family income and individual work status. A comparison of the data in Tables 4 and 5 shows that while 56 percent of uninsured adult workers earn less than $20,000, 52 percent of all uninsured adults actually have family incomes in excess of $30,000.

The presence of families with two or more workers as an explanation for the phenomenon can be seen from the following hypothetical example. Consider a family with a primary worker earning $35,000 a year and a part-time, secondary worker earning $10,000 a year. If only the adult earning $10,000 were working the family income would be about 65 percent of poverty. Conversely, if only the adult earning $35,000 were working the family income would be about 250 percent of poverty. However, with both adults working the total family income is $45,000, just over 300 percent of poverty or about 80 percent of Maryland's median family income. Thus by any measure their income puts them in the middle-class. Yet at least one and possibly both adults are uninsured. Furthermore, if children are present in the family they are probably uninsured as well, as the family's total income puts them above the eligibility threshold for SCHIP coverage.

Table 5: Maryland Uninsured Adults by Work Status and Family Income, in 2003

Income in Dollars and as Percent of Poverty Level	Adult Workers	Adult Non-Workers
Poor (<=$14,810) (<= 100%)	50,000	70,000
Near Poor ($14,810 - $29,620) (101% to 200%)	130,000	40,000
Low Moderate ($29,620- $44,430) (201% to 300%)	90,000	10,000
Mid Moderate ($44,430 -$59,240) (301% to 400%)	60,000	10,000
High Moderate ($59,240 - $88,860) (401% to 600%)	60,000	10,000
High ($88,860+) (601%+)	60,000	10,000
TOTAL	450,000	150,000

As expected, uninsured workers in Maryland are predominantly employed by smaller firms. However, while 46 percent of uninsured workers are employed in firms with 24 or fewer employee, uninsured workers are present in significant numbers throughout the state's economy. The data on uninsured workers by employer type and size, presented in Table 6, show that 100,000 uninsured workers are employed by private firms with 500 or more employees, and a further 30,000 have jobs in federal, state or local government. Taken together, private firms with 500 or more workers and governments employ 120,000 uninsured workers in Maryland, or just over one-quarter (26 percent) of all uninsured workers in the state.

Since these are all large employers and they all sponsor employer-group health insurance plans, it can be reasonably inferred that, even under the best of circumstances, employer-group health insurance has significant limitations as a coverage model. It is likely that most of these uninsured workers are lower-paid, part-time, temporary, or contingent workers. However, among them are also probably a number of fairly well-paid consultants who, because they are contract workers and not employees, lack access to employer-sponsored health benefits. Also, some subset of these workers, most likely younger, lower-wage ones, may in fact be eligible for coverage but declined it because they do not view it as worth the money.

Table 6: Maryland Uninsured Workers by Type of Employer and Firm Size, in 2003

Business Sector & Size (# Workers)	Number	Percent of Total	Uninsurance Rate of Employer Category
Federal government employee	10,000	2.17%	4%
State & Local government employee	20,000	4.35%	5%
Private firm 500+ employees	100,000	21.74%	12%
Private firm 100-499 employees	50,000	10.87%	17%
Private firm 25-99 employees	70,000	15.22%	20%
Private firm 10-24 employees	60,000	13.04%	26%
Private firm < 10 employees	110,000	23.91%	35%
Self-employed, firm < 10 employees	40,000	8.70%	21%
TOTAL	460,000	100.00%	n/a

MANY "UNINSURED" ARE ACTUALLY COVERED BY MEDICAID

The big caveat in analyzing data on the uninsured population is that solid evidence demonstrates, particularly in Maryland, that much of the data are simply incorrect. Specifically, coverage estimates derived from Census Bureau surveys show significantly fewer Medicaid enrollees than the enrollment numbers reported by state Medicaid agencies.

There is widespread agreement among experts that Census Bureau surveys of health insurance coverage significantly undercount the number of individuals actually enrolled in Medicaid and SCHIP. In fact, two recent studies of the issue commissioned by the federal Department of Health and Human Services, one by the Urban Institute and one by the Actuarial Research Corporation, produced estimates for the nationwide size of the Medicaid undercount of between four and nine million individuals.[5] Those individuals appear to be misidentified in the Census surveys as either having private coverage or being uninsured.

Researchers have identified several likely reasons for the undercount. One major factor appears to be that many states give different names to their Medicaid and SCHIP programs. For example, Maryland calls its general Medicaid program "Maryland Medical Assistance" and its Medicaid managed care program "HealthChoice." Similarly, the California Medicaid program is called "MediCal," while in the District of Columbia the SCHIP program is part of Medicaid but goes by the name "DC Healthy Families." Thus, enrollees may think of those names, and not "Medicaid," when asked about their health coverage. Another possible factor is that some individuals know they are covered by Medicaid, but do not want to admit it when asked.

Unlike other states, Maryland lawmakers have a big advantage in this regard since the Department of Health and Mental Hygiene (DHMH) recently commissioned a detailed study of the true number of Maryland Medicaid enrollees.

The starting point for the study was:

> According to the U.S. Census Bureau's Current Population Survey (CPS), approximately 441,000 individuals were enrolled in the Maryland Medicaid program at some point in calendar year 2003. State Medicaid enrollment data, however, recorded that nearly 713,600 of the State's residents participated in Medicaid during that period—a discrepancy of about 272,600 individuals.[6]

The study sought to determine how much of that discrepancy might be attributable to Census *under-*

5. Actuarial Research Corporation, "Estimating the Number of Individuals in the U.S. Without Health Insurance," April 8, 2005 at http://aspe.hhs.gov/health/reports/05/est-uninsured/index.htm and Linda Giannarelli, Paul Johnson, Sandi Nelson, and Meghan Williamson, "TRIM3's 2001 Baseline Simulation of Medicaid and SCHIP Eligibility and Enrollment: Methods and Results," *TRIM3 Microsimulation Project Technical Paper*, April, 2005 at http://aspe.hhs.gov/health/reports/05/medicaid-schip-simulation/index.htm

6. Center for Health Program Development and Management, University of Maryland Baltimore County, "The Maryland Current Population Survey Medicaid Undercount Study," July 25, 2005. at www.dhmh.state.md.us/mma/pdf/CPSSurvey_Report.pdf

counting Medicaid enrollees and how much might be attributable to errors in the Maryland Medicaid administrative files that result in DHMH *over-counting* Medicaid enrollees.

The study concluded that most of the difference could be attributable to several features of the Census survey questionnaire that generate incorrect responses. However, it also concluded that errors in DHMH's Medicaid records could be responsible for a Medicaid over-count ranging from a minimum of 1 percent (7,136 enrollees) to a maximum of 7 percent (50,666 enrollees).

Thus, the correct Maryland Medicaid enrollment should be the DHMH figure minus the estimated over-count. It would appear, then, that about a quarter-million Marylanders (somewhere between 222,000 and 265,000) are actually enrolled in Medicaid but are tabulated under some other coverage category in the Census coverage data.

This raises another question, which unfortunately was beyond the scope of the study. Namely, how many of those quarter-million Medicaid recipients are misidentified as *uninsured* in the Census data? The answer is, probably most of them. Indeed, as the Maryland study noted, other studies indicate that on a national basis the Census CPS survey seems to underestimate the Medicaid population by about 20 percent and over-estimate the uninsured population by about 20 percent as well.

Regardless of the precise numbers, the major implication of correcting Census estimates to conform them to the realities of state Medicaid enrollment would be to conclude that, in fact, there are significantly fewer low-income uninsured in Maryland than the Census data otherwise indicate. This is because any Medicaid enrollee misidentified as uninsured must, by definition, be low-income to qualify for Medicaid coverage in the first place.

In Maryland, the relevant family income thresholds for Medicaid/SCHIP eligibility are:

- Adults with family incomes below 39% of poverty.
- Pregnant women with incomes below 250 percent of poverty.
- Children with family incomes below 200 percent of poverty.
- Families with incomes between 200 and 300 percent of poverty who can buy-into subsidized SCHIP coverage for their children by paying part of the premium.

By comparison, Table 7 gives a breakout of Census data on the Maryland low-income uninsured by family income and adult/child status. According to the Census data there are 160,000 uninsured Marylanders with family incomes below 100 percent of poverty and a total of 360,000 below 200 percent of poverty. But, the Census data appear to underestimate Maryland Medicaid/SCHIP enrollment by 222,000 to 265,000 individuals. Thus, the vast majority of low-income Marylanders that the Census data labels as "uninsured" are most likely in fact currently covered by Maryland's Medicaid and SCHIP programs.

Table 7: Maryland Low-Income Uninsured Adults and Children, in 2003

Family Income as Percent of Poverty Level	Adults	Children
Poor (<= 100% FPL)	120,000	40,000
Near Poor (101% to 200% FPL)	170,000	30,000
Low Moderate (201% to 300% FPL)	100,000	20,000

THE FAIR SHARE FUTILE GESTURE

Proponents of the Fair Share Act argued that employers have an obligation to purchase a minimum level of health insurance coverage for their employees, and that employers who do not do so are not paying their "fair share." Their solution is to penalize those employers with a new payroll tax, with the proceeds going to fund health care for uninsured workers.

> It pushes companies that currently don't provide quality, affordable health care to begin doing so. And if these companies refuse to invest in their employees, the law puts more funds into health care expansion so that more Marylanders get access to high quality, affordable care.[7]
>
> Our Fair Share Health Care legislation would set a minimum standard for health care; it requires large employers to pay

7. Maryland Health Care for All! Coalition, "Why Fair Share Health Care?," at www.healthcareforall.com/HTML32.phtml

> their fair share for health care (defined as a percentage of total wages) or pay into a state fair share health care fund that can be used to provide or subsidize health care for uninsured workers in the state.[8]

But a closer examination of the provisions of the Fair Share Act, particularly in light of the data on the Maryland uninsured, show that legislation is nothing more than a futile gesture that will have no meaningful effect on health insurance coverage.

The first, and biggest, fallacy of the Fair Share approach is the premise that employers somehow 'pay' for health insurance for their workers. But employers do not really pay for employee health insurance—the workers themselves do. From an employer's perspective, what really matters when hiring a worker is the total compensation cost.

To understand this, consider the case of a job for which a business is willing to spend a total of $30,000 per year for a qualified worker to fill the position. It makes little difference to the employer if it gives the worker $5,000 of health insurance and $25,000 in cash, or alternatively gives the worker the whole $30,000 in cash. But, to the worker it makes a big difference, and federal and state tax policy is the reason why.

From the employer's perspective it does not matter much if it pays its workers in the form of cash, pension contributions, health benefits, use of a company car, or even bags of groceries delivered to their doorsteps—all are employee *compensation.* And, under the corporate income tax code, almost any employee compensation is a deductible business expense. Businesses only pay taxes on their net profits, or what's left after subtracting expenses, including employee compensation, from income.

However, from the employee's perspective, the manner in which the employer pays him matters a great deal and can make a big difference. The federal and state personal income tax codes treat cash wages, use of a company car, and most other non-cash compensation, such as employer-purchased bags of groceries, as income to the worker and impose income and payroll taxes on the value of those items.

However, employer payments for health insurance and pensions are the big exceptions to this rule. Current tax law does not consider the value of those benefits as taxable income to the worker. This type of tax provision is called a "tax exclusion." In other words, that portion of a worker's compensation that the employer pays to him in the form of health insurance benefits is "excluded" from calculation of the worker's taxable income. Thus, those benefits are tax-free to the worker—with the worker paying no federal or state income tax or Social Security or Medicare payroll tax on that portion of his or her income.

Were the laws to instead apply the same tax treatment to payments for employer-group insurance and for non-group insurance, (either the same tax break for both, or no tax break for either), workers would have little reason to ask their employers to pay for all or part of their health insurance, and most employers would have little reason to offer their workers those benefits. Instead, workers would take all of their wages in cash, and then make their own arrangements for buying health insurance, just as they now do with auto, life, or homeowners insurance.

In fact, the only other reason, besides the tax code, for employers to provide their workers with employer group insurance is that in most cases employer-group coverage is cheaper than the coverage offered in the non-group market. But even that price difference is not immutable. Rather, it is the product of long-standing insurance industry practices and government insurance regulation. It would indeed be possible, by applying a different set of insurance regulations, to equalize the pre-tax cost of employer-group and non-group health insurance policies.

Thus, a proper understanding of the economics of employee benefits leads to recognition of the first of six major flaws in the Fair Share Act:

8. AFL-CIO, "AFL-CIO President John Sweeney Remarks on Fair Share Health Care Campaign," January 05, 2006, at www.aflcio.org/mediacenter/prsptm/sp01052006.cfm

Flaw #1: Workers will actually bear the cost.

If an employer is paying less than specified percentage of payroll for health insurance and then complies with the Fair Share Act by increasing the amount spent on worker health insurance, the employer will offset that increased health spending with decreased spending cash wages. Again, this is because what matters to the employer is total employee compensation, not how that compensation is divided up or paid out. It is true that, given the marginal amounts involved, workers probably will not see their cash wages reduced.

More likely what will happen is that a larger share of future compensation increases will go to health care benefits instead of cash wages. Thus, the minimum percentages (8 percent in the case of for-profits and six percent in the case of non-profits) are effectively a hidden payroll tax imposed on workers in the affected firms. Requiring employers to divert more of the wages they pay their workers into health benefits or taxes does not make those workers any better off. This, then, is the first reason why the Fair Share Act is just a futile gesture.

Flaw #2: Does not apply to governments.

The legislation includes a clause specifying that its provisions do not apply to the federal, state or local governments. According to the Fiscal and Policy Note accompanying the bill, there are currently three private entities in Maryland with more than 10,000 workers to whom the Fair Share Act would apply. They are: Giant Food (18,902 employees), Johns Hopkins University (14,729 employees), and Wal-Mart (14,301 employees).[9]

However, according the report by the Maryland Health Care Commission, there are currently 10,000 federal workers in Maryland who are uninsured and a further 20,000 state and local government workers who are uninsured. While the state cannot apply its laws to the federal government, it can certainly apply them to itself and to its county and municipal governments.

If the proponents of the Fair Share Act were serious about expanding coverage to the uninsured, they would have included state and local governments, whose population of *uninsured* workers is larger than the *entire workforce* of any single private employer in the state. The fact that they did not do so is the second reason why the Fair Share Act is just a futile gesture.

Flaw #3: Treats non-profits differently

The legislation would require for-profit employers to spend 8 percent of payroll on health benefits or pay the difference to the state in a tax. But in the case of non-profit employers, the requirement is only 6 percent of payroll. Of course, this makes no economic sense. Health insurance plans don't come with a magic 20 percent discount for non-profits. In the real world a group health insurance plan for any given employer will cost the same, regardless of the for-profit or non-profit status of the employer. Presumably, the 20 percent difference in the mandate amount was included for political reasons. But far from being a justification, such an explanation merely reinforces the fact that the legislation is not serious health policy. Instead, it is the third reason why the Fair Share Act is just a futile gesture.

Flaw #4: Employers can pay a fine.

The act provides for a $250,000 fine for failure to comply. Thus, if it would cost an employer more than $250,000 to bring its health benefit spending up to the required level, simply paying the fine becomes a rational alternative. That an employer might take such an approach can be expected given the sums involved. According to the Fiscal Note, the three employers affected by the law would have to spend the following amounts on health benefits to be in compliance: Giant Food, $43 million; John Hopkins, $52 million; and Wal-Mart, $22 million. While fining a non-compliant employer may give satisfaction to Fair Share supporters, it doesn't get any of the uninsured health insurance coverage, and thus is the fourth reason why the Fair Share Act is just a futile gesture.

Flaw #5: Employers can increase spending with out expanding coverage.

Assuming an affected employer is not in compliance, nothing in the Fair Share Act either requires, or even encourages, the employer to achieve compliance by covering its uninsured workers. Instead, since these are very large employers who already insure most of their workers, the easiest way to achieve compliance is to simply spend more money

9. Maryland General Assembly, Department of Legislative Services, "Fiscal and Policy Note HB 1284," at http://mlis.state.md.us/2005rs/fnotes/bil_0004/hb1284.pdf

on health benefits for already insured workers. Once again, that does not get any of the uninsured health insurance coverage, and is thus the fifth reason why the Fair Share Act is just a futile gesture.

Flaw #6: Does not require the state to expand coverage.

Assuming that one or more non-compliant employers actually ends up paying fines or taxes to the state under the provisions of the Fair Share Act, the legislation dedicates any funds so collected to the state's Medicaid program. But the legislation makes no provision that any such funds be used to expand coverage. Theoretically, an uninsured individual working for a non-compliant employer might get Medicaid coverage. But that would depend on the worker applying for Medicaid and meeting the program's eligibility criteria. Such an eventuality would be purely the result of coincidence, and could not be attributable to the enactment of Fair Share. Thus, even monies collected by the state in fines and taxes under the provisions of the Fair Share Act would not result in any of the uninsured gaining coverage, making it the sixth reason why the Fair Share Act is just a futile gesture.

STEPS TO REAL REFORM

Instead of wasting their time on frivolous and futile gestures of political symbolism, like the Fair Share Act, Maryland's lawmakers should have focused their attentions on the serious task of expanding coverage to the currently uninsured by reforming the state's health insurance system.

To start with, a close look at the composition of the state's uninsured population suggests the outlines of meaningful reforms. In particular, the conclusion that the majority of Maryland's low-income uninsured are, in reality, not actually uninsured, but rather covered by Medicaid and SCHIP, has two very important implications for lawmakers with respect to designing policies to expand health insurance coverage in Maryland.

The first implication is that with the right mix of policies lawmakers may in fact be able to achieve something close to universal coverage with no more than a modest increase in state spending.

The second implication is that most of the Maryland's uninsured individuals are in, or near, the middle class in terms of their family incomes. Thus, getting them coverage is more an issue of solving the problems of availability and value, than the problem of affordability *per se*.

The data on the uninsured indicate that many of them are part-time or contingent workers, including significant numbers employed by federal, state, and local governments and large private employers. Anther significant share consists of those working for small businesses, particularly "micro" businesses with 10 or fewer employees and the self-employed. Finally, almost all of the remaining uninsured individuals are the dependents of workers in the first two categories. This suggests the basic elements of a coverage solution:

Element 1: Create a new administrative system for making coverage more readily available to workers with non-traditional employment situations.

The state should reform its insurance markets to create a new, statewide "health insurance exchange" through which insurers would offer policies that combine the best features of the current group and non-group insurance markets. As in the current group market, the exchange would offer an annual open season during which participants could select or switch coverage, and health status would not be a rating factor. However, as in the current non-group market, premiums for coverage would be age and geography adjusted (within specified limits), and coverage would be fully portable, with participants able to keep their chosen coverage when changing jobs or employers.

Element 2: Create a new system for "aggregating" premium payments from multiple sources.

A new, statewide "health insurance exchange" should also include mechanisms that facilitate employers and workers making pre-tax contributions toward coverage, such as through payroll withholding. It should also be set up to combine contributions from multiple sources. For example, a two-earner couple would no longer have to choose coverage from one spouse's employer and forgo the coverage contribution offered by the other spouse's employer. Instead they could combine the contributions from both employers and use the total amount to buy the coverage they really want for their family through the exchange. Similarly, an individual with two part-time jobs could ask for a pro-rated contribution from each employer and

then combine them to buy coverage through the exchange.

Furthermore, with these first two reform elements in place, small employers would no longer face the risks and administrative burdens associated with trying to obtain group coverage for their handful of employees. Rather, a small business could designate the exchange as its health insurance plan and give its employees whatever tax-free contribution the business can afford to help them buy coverage. Insurance brokers could continue to receive commissions for bringing those businesses and workers to the exchange. They would "earn" their commissions by providing workers with benefits counseling on picking the best plan for their personal situations, and by assisting employers in setting up arrangements, currently permitted under federal and state tax law, that make the share of the premium paid by their employees also tax-free to the workers. While such arrangements are common among large firms, today small firms rarely offer them.

Element 3: Cover state and local government employees through the exchange.

If the state and local governments took the lead by providing health insurance to their own employees through the exchange it would have a number of positive effects. First, their workers would gain a wider choice of coverage options. Second, it would facilitate getting coverage to the approximately 20,000 state and local government employees who are currently uninsured. Third, the presence of such a large number of workers (about 320,000) plus their dependents would be a catalyst for ensuring the exchange's success. Insurers would have a huge market incentive to offer attractive benefit packages at attractive premiums through the exchange, while small businesses and their employees would be eager to join.

Finally, the costs of coverage for state and local workers might actually decline somewhat under such an arrangement. This is because the average age of workers with employment-based insurance tends to be significantly higher that the average age of the uninsured. For example, 15 percent of Maryland workers are aged 55-64, but they account for 17 percent of all workers with employer-provided health insurance and only 6 percent of the uninsured, while in contrast 12 percent of Maryland workers are aged 19-24, but they account for only 6 percent of all workers with employer-provided health insurance and 22 percent of the uninsured.[10] Thus, expanding coverage to uninsured workers who are generally younger and healthier should have a favorable impact on premiums for all covered individuals.

Element 4: Permit a wider array of coverage options.

Maryland's health insurance markets are among the most overregulated in the nation. Indeed, Maryland leads all other states in the number of mandated health insurance benefits (46 mandates) imposed on non-group health insurance policies.[11] Maryland has also standardized coverage in the small-group market into a one-size-fits-all package of benefits administered by the Maryland Health Care Commission. These policies need to be reversed, not only to make health insurance more affordable in the state, but to also address the somewhat justified perception among young, healthy individuals that buying coverage is today a bad value.

The state should scale back its regulation of health insurance and retain only those provisions essential to ensure four things:

1) insurer business practices that are financially sound;

2) rates for each product that are reasonably commensurate with the actuarially anticipated costs and risks associated with the particular product;

3) fair and truthful advertising and sales practices, and;

4) coverage mandates that are limited to only broad categories of benefits, such as hospital, physician, drug, and mental health benefits.

The specific forms of coverage, the size of coverage deductibles and copays, and the restrictions, if any, on access to providers under the various plans, should be the product of insurer responses to mar-

10. Author's calculations using data from Maryland Health Care Commission, "Health Insurance Coverage In Maryland Through 2003," November 2004.

11. See Michael J. New, Ph.D., "The Effect of State Regulations on Health Insurance Premiums: A Preliminary Analysis," Heritage Foundation *Center for Data Analysis Report #05-07,* October 27, 2005.

ket demands—not determined by politicians or committees of 'experts.'

Element 5: Redirect existing subsidies to covering the remaining low-income uninsured.

A close analysis of the Maryland uninsured population and the Medicaid undercount indicates that with the right reforms the state could achieve significant coverage expansions at a public cost well below what might, at first, be expected. Even so, getting to universal, or near universal, coverage in Maryland will still require some additional subsidies for the near-poor uninsured.

The good news, however, is that in Maryland, as in every other state, significant federal and state funds are already available to meet this need. They are monies that are currently being spent to subsidize hospitals and clinics for the cost of treating the uninsured. Based on data from a recent study it would appear that, at a minimum, in Maryland between $150 million and $200 million in federal and state Medicaid and Medicare money could be redirected into subsidizing coverage for the near-poor uninsured, thus transforming the current "provider safety-net" into a true "patient safety-net."[12]

CONCLUSION

For Marylanders, the good news is the state already has a robust economy with incomes and health insurance coverage rates above the national norms; a residual uninsured population that is in fact much smaller than reported and predominantly employed with family incomes that are lower-middle class or better; and substantial public funding available to redirect into health insurance coverage subsidies. All that is missing to achieve something approaching universal health insurance coverage in Maryland is the right set of health insurance market reforms and health care deregulation, and the political leadership to enact them.

However, the bad news for Marylanders is that, unfortunately, their lawmakers were diverted into a protracted debated over symbolic, but completely ineffectual, legislation dressed up as health policy. Also unfortunate is that, in failing to follow up the Governor's veto of the Fair Share Act by offering a substantive alterative, the Ehrlich Administration missed an opportunity to redirect the legislature toward a more meaningful health reform debate. Thus, with the General Assembly's enactment of a veto override, the Governor's veto was consigned to the role of just another futile gesture in the drama.

This sorry state of affairs was encapsulated in a recent news story, which reported that:

> After listening for weeks to the pros and cons, [Delegate Sue] Kullen declared a few days ago that she intended to vote for the override even though she doubted that the bill would have a big impact on health care. "This is a kick in the pants for Wal-Mart," she said.[13]

'Kicking' a disfavored company may make some lawmakers feel good but it does nothing to help the uninsured in Maryland. Apparently, at least some of Maryland's legislators knew that the legislation wouldn't achieve anything, but decided to go on 'kicking' Wal-Mart anyway. Marylanders have a right to expect real solutions from their elected representatives—not just futile gestures. Enacting ineffective laws is no way to reform health care.

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12. Johns Hopkins Bloomberg School of Public Health, "The Costs of Not Having Health Insurance in the State of Maryland," December 22, 2003 at www.dhmh.state.md.us/hrsa/pdf/Costs-Uninsurance-inMD.pdf

13. Bill Lambrecht, "Wal-Mart benefits furor is spreading across U.S.," *St. Louis Post-Dispatch*, January 10, 2006.