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Health system reform legislation recently passed in Maryland attempts to address the dual problems of rising health care costs and inadequate access to health insurance coverage primarily through government regulation of insurers and health care practitioners. The legislation builds on years of state experience with hospital rate setting and a willingness to adopt a regulatory approach in the private insurance market.

While the new legislation includes some provisions that may apply only to Maryland, it could offer a paradigm for states that are willing to accept a regulatory solution. Maryland’s health system reform may be especially appealing to states with a geographically diverse population where a managed competition model would be difficult to implement or sustain. The legislative debate in Maryland over health care also could offer insights into the types of political compromises that may be necessary for health reform legislation to pass at the national level.

**Background.** Maryland has embraced regulation of health care providers and insurers since the early 1970s. In 1976 Maryland implemented the first all-payer hospital prospective payment system, and while other states have tried all-payer rate setting in the intervening years, Maryland is the only state that has stayed with its program. The Maryland system is widely perceived to be successful in controlling hospital costs per admission, although more recent data have questioned how well it has been able to constrain the growth in per capita hospital spending. The rate-setting program prohibits hospitals from offering price discounts to any insurer or managed care organization, except for minor discounts for prompt payment. Maryland has more mandated health benefits than any other state, and it continues to operate an active certificate-of-need (CON) program. Thus, it is not surprising that Maryland turned again to regulation when it passed legislation reforming the health insurance system, controlling practitioner payment rates, limiting charges for diagnostic tests, and establishing medical practice parameters.

Enacted 9 April 1993, the Maryland reform legislation can be separated into two parts: provisions aimed at increasing access to health care through insurance reform, and provisions aimed at containing health care costs. With respect to health insurance reform, Maryland has followed the lead of several other states that have already taken a proactive stance in such reform. It has, however, enacted several new provisions that are unique to Maryland, such as limiting the premium cost of the standard health benefit plan to a percentage of average wages. With respect to cost containment, Maryland continues to be an innovator, taking the lead in addressing practitioner payment at a state level.

We begin with a description of the legislation, placing particular emphasis on the
role of the new Health Care Access and Cost Commission that has broad powers to implement the legislation. We then discuss the evolution of the legislation and conclude by highlighting lessons that the Maryland reforms may hold for other states and the federal government as they continue their debates over health system reform.

**Health System Reform In Maryland**

The preamble to the legislation lists twenty-six reasons why health system reform in Maryland was considered necessary, including the following: (1) Hospital rate setting in Maryland has worked to slow the increase in hospital costs. (2) Maryland has a comprehensive database on hospital costs and services but no comparable information on costs and services rendered by other health care providers. (3) The thirty-two state-mandated benefits apply to only 20 percent of the population. Self-insured organizations are governed by federal Employee Retirement Income Security Act (ERISA) requirements and are therefore not subject to state insurance regulations. (4) Many Maryland businesses continue to experience increases in health insurance premiums of 15 to 20 percent each year. These employers, along with many of the uninsured, are willing to purchase health care coverage but cannot afford the premiums. (5) Over 15 percent of Maryland state residents under age sixty-five do not have health insurance. (6) Providers, payers, and planners must undertake cooperative efforts to develop appropriate guidelines for the practice of efficient medicine.

The Maryland legislation creates a powerful new commission, the Maryland Health Care Access and Cost Commission. This commission, along with input from a new Advisory Committee on Practice Parameters and the Maryland Standard Benefit Plan Task Force, was given a broad mandate to achieve the following objectives: establish a statewide health care database on all health care practitioners, compare and analyze fees charged by health care practitioners, develop a payment system for office-based health services, establish medical practice parameters, and develop a comprehensive benefit package. The access and cost commission is patterned after the Maryland Health Services Cost Review Commission (HSCRC), which was established in 1971 to regulate hospital rates. Both commissions have members appointed by the governor, have a majority of members who are not health care providers, and have an executive director appointed by the commission. The HSCRC has enjoyed relatively little political interference; it is uncertain whether the new commission will experience such autonomy.

**Data collection.** The authors of the legislation recognized that the data currently available on licensed practitioners were inadequate to accomplish the span of legislative objectives that they had envisioned. The commission lacked data to compare fees, practice patterns, or quality of care among practitioners; nor would it be able to assess the performance of health maintenance organizations (HMOs).

Thus, the first task of the commission will be to establish a statewide database on ambulatory patient encounters with physicians and other health care practitioners. For each patient, data will be collected on demographic characteristics, principal diagnosis, procedures performed, charges for procedures, and whether or not the bill was submitted on an assigned or nonassigned basis. The HSCRC already is responsible for collecting data on hospital inpatient and outpatient services, which include patient demographic information, diagnoses, charges, and lengths-of-stay. It also compiles information on the financial status of Maryland hospitals. The new commission will ensure that the data collection effort is compatible with the HSCRC’s existing data collection. It is envisioned that the two data sets ultimately will be merged.

Besides being an inconvenience, the administrative burden placed on providers by the multitude of claims forms used by insurers adds to the overall cost of care. To address this issue, the commission was given authority to limit the number of claims clearinghouses in Maryland. By stand-
ardizing the data format and regulating electronic claims clearinghouses, the commission is expected to reduce administrative burden on practitioners. Considering the time and effort physicians and their staffs spend understanding billing requirements, this provision could enable large administrative cost savings.4

Fee comparisons. Both in Maryland and throughout the United States, wide variation exists in the fees charged for medical services and in reimbursements for those services across payers.3 The Maryland legislature adopted provisions to implement a new payment methodology based on a fee comparison system. The commission is required to develop and implement such a system by 1 January 1995.

The Maryland method is based on three factors: a provider-specific component representing resources necessary to provide health care services, a procedure-specific component based on Current Procedural Terminology (CPT) codes, and a conversion modifier. The first factor is based on a practitioner’s malpractice costs, bad debt and charity care burden, experience and expertise, education, geographic variation in practice cost, overhead, and costs associated with teaching responsibilities. The second factor takes into consideration the relative complexity of the service or procedure rendered, cognitive skills involved, time and effort, and other factors determined by the commission. The third component of the fee schedule translates the service or procedure into a dollar value. The conversion modifier will be determined either by the payer, by the practitioner, or through an agreement between the payer or patient and the practitioner. Although the three components are outlined in the legislation, the law leaves considerable discretion to the commission.

The commission is instructed by law to consider the Medicare resource-based relative value scale (RBRVS) in developing a physician payment system, although this is not a formal condition for implementing the physician payment system. A 1992 report by the Physician Payment Review Commission (PPRC) examined the potential for extending the Medicare physician payment methodology to other payers. According to the PPRC, several adjustments would need to be made to apply the Medicare RBRVS more broadly. For example, all payers would have to use CPT coding, which would need to be addressed in the data collection phase. A standard definition of what services should be included in the global fees is another issue that the commission must consider if there are going to be comparisons across insurers.

Although the current Medicare physician work values were calculated for a general population, more research may be needed to develop work values related to obstetrical and pediatric services. According to the PPRC, these relative values are likely to be distorted and would need to be adjusted; for example, certain services provided to children may require more work than when they are provided to adults.6 Development of a pediatric adjuster may prove to be a substantial undertaking. Whether or not it chooses to follow the Medicare RBRVS model, the commission will need to address a number of issues before it is able to undertake a valid comparison across practitioners and payers.

The legislative provision outlining the mechanism for determining conversion modifiers may generate intense debate. The provision has been interpreted to suggest that practitioners can set their own conversion factor, that they must do so in conjunction with payers, or that the commission has the authority to set the conversion factor. The new law also suggests that the commission will be responsible for establishing cost containment goals for expenditures; however, the legislative language is ambiguous surrounding this issue.

The cost containment strategy for provider services will begin as a voluntary and cooperative arrangement between providers and the commission. If the commission determines that providers of a particular specialty have excessively high charges or are achieving unreasonably high levels of reimbursement, the commission has the authority to work with that group to bring them into compliance or to adjust the conversion modifiers accordingly. Similarly, if charges for certain medical services in-
crease to exceed the commission’s cost containment goals, the commission is authorized to establish mandatory rates.

The state medical association has expressed concern over the use of undefined terms throughout the legislation with regard to the new practitioner payment provisions. Terms such as unreasonable and voluntary are not explicitly defined, and the legislation also is unclear in delineating the circumstances that would trigger mandatory controls. What is clear from a health financing standpoint, however, is that voluntary hospital rate-setting programs have been found to be less effective than mandatory programs in controlling cost increases. The authority of the commission to impose mandatory rates in response to excessive cost and reimbursement is not clearly defined; this may result in legal challenges in court.

Practice parameters. Outcomes research and the development of practice guidelines are increasingly employed to control costs and improve the quality of health care. The Agency for Health Care Policy and Research (AHCPR), medical specialty societies, and insurers all have attempted to reduce variation in medical practice through the development and dissemination of guidelines. Experience has shown, however, that although practitioners are aware of, understand, and agree with practice parameters, they do not always change their behavior. A study of obstetricians in Ontario found that most practitioners said they were aware of guidelines on the appropriate use of cesarean section, and nearly 85 percent agreed with the guidelines. However, data on physician behavior following publication of the guidelines revealed that the actual rate of procedures being performed was 15-49 percent higher than the rates reported by the obstetricians themselves, and the percentage of cesarean sections continued to increase. Legal constraints and financial incentives are among the reasons why practice guidelines have not always changed medical practice.

To give government imprimatur to practice guidelines, Maryland will create an Advisory Committee on Practice Parameters, to study and recommend the adoption of parameters for use in Maryland. The commission can adopt a recommended practice parameter if three conditions are met: (1) 60 percent of specialists in the state, whose practices will be affected, vote to adopt the guideline; (2) it is determined that the guideline will reduce unnecessary use of services; and (3) the guideline will maintain high quality standards. Any parameters adopted by the commission are in effect for only three years, although they may be amended or readopted at any time.

Contrary to what the state medical association urged, the manner in which practice parameters would be used in court as evidence in a malpractice suit remains unchanged. Maryland physicians had lobbied for use of the parameters as an affirmative defense to control defensive medicine. After committee members proposed that the parameters be permissible as evidence by either the plaintiff or defense, practitioners objected, and a compromise was reached that neither side could introduce the guidelines in legal proceedings.

As the law is written, there is no incentive for physicians to adopt statewide practice guidelines. Because the law does not provide for enforcement mechanisms and because the practice parameters have no status in a court of law, it is questionable whether physicians would follow guidelines that substantially changed existing practice.

Malpractice reform. For many years, as part of its quality assurance effort, Maryland has collected information on medical malpractice claims. All claims involving health care practitioners that result in a final judgment, final disposition, or a settlement are reported by the malpractice insurance company to the Physician Board of Quality Assurance. Claims involving hospitals are reported to the state Department of Health and Mental Hygiene. Beginning 1 July 1993, this information also must be reported to the new Health Care Access and Cost Commission. The purpose for this extra reporting step is unclear. The legislation does not address whether the commission has the authority to affect payment rates or practitioner reimbursement based on information gleaned from malpractice data.
The Maryland effort is analogous to the system maintained by the Bureau of Health Professions of the U.S. Public Health Service. Since 1990 the bureau has been collecting data on payments made on behalf of practitioners in medical malpractice cases as part of the National Practitioner Data Bank. In fact, to some degree there is a duplication of effort, since payers must report this information to the state and federal governments. Additional information on final dispositions not resulting in payment is required for state reporting, however.

The Maryland health care reform bill also contains a provision that was intended to limit physician liability. According to the new law, physicians are not liable for damages in medical malpractice cases unless the plaintiff can establish that the care rendered was not in accordance with generally accepted standards among members of the same profession with similar training and experience in the same or a similar community. This provision is intended to put more reasonable limits on the use of hired expert witnesses. However, because it recognizes differences in medical practice across communities, it does not promote a uniform standard of care throughout the state.

Health insurance reform. The purpose of the health insurance provisions of the Maryland reform bill was to make health insurance affordable to employees of small businesses. Beginning 1 July 1994 insurance carriers in Maryland are required to offer a comprehensive standard benefit package to employers with two to fifty employees who work at least thirty hours per week. By 1995 exclusions based on preexisting conditions will be prohibited. These reforms are consistent with federal efforts to incorporate a comprehensive benefit package into health care reform with few restrictions on who can enroll in the various plans.

To ensure that health insurance remains affordable, insurers will use an adjusted community rating system to set rates applied to the standard benefit package. Initially, the rates may be adjusted only by age and geographic region, although adjustments in the community rate will be gradually reduced over four years to 16 percent above or below the community rate. On or before 1 October 1998, the state insurance commissioner is required to issue a report on the feasibility of implementing a pure community rate—that is, one that does not adjust for age, gender, or other differences across patients.

The average community-rated premium is limited to 12 percent of the average annual wage in Maryland. Currently, the average health benefit plan for Maryland state employees—a group policymakers considered as a model for benefit package design—represents 13 percent of the average annual wage. This law provides, however, that if the average community rate exceeds 12 percent, the commission must alter the standard benefit package. Tying health care contributions and rates of increase to workers’ salaries may be unique in this country, but it is standard practice in other countries such as Germany. German employees’ contributions are a fixed proportion of salaries and are calculated without regard to any health care risk or prior utilization patterns.

The reforms imposed on the small-group market will be made applicable to large businesses and individuals if one of two conditions is met. First, the reforms would apply to the entire market if 60 percent of the Maryland population under age sixty-five is willing to be covered by an insurer or a managed care plan and not through a self-insured plan. This requirement was included to ensure an adequate risk pool. Although many interested parties pressed for a lower trigger rate, insurers were successful in retaining the high threshold in the legislation. The threshold is so high that it is questionable whether this trigger could be reached. Second, the application of the reforms would be expanded if ERISA is amended to give states the authority to regulate employer health benefit plans. The Maryland legislature believes quite strongly that ERISA has hindered state efforts to reform health insurance, since it exempts self-insured health benefit plans from state insurance regulation and allows self-insured entities to create their own low-risk pools.

The new law reforms the small-group market in other ways: guaranteed issue of health benefit plans, providing that insurer
requirements on minimum participation are maintained; limits on preexisting condition exclusions; and portability of health benefits for workers who change jobs.

This legislation does not require small employers to provide health care benefits to their employees. Thus, although insurers are required to offer at least the standard benefit package to small businesses, it is unclear how many employers will take advantage of the newly available benefit packages. Consequently, although health insurance benefits will be more affordable, there is no guarantee that the number of working uninsured persons will be reduced.

Additionally, the law allows the state insurance commissioner to require the filing of new rates whenever the loss ratio or expense ratio for a health benefit plan falls outside specified limits. Maryland also has adopted guidelines developed by the National Association of Insurance Commissioners (NAIC) regarding reinsurance pools. Specifically, the carrier is responsible for claims up to $5,000; the carrier is responsible for only 10 percent of all payments for claims between $5,000 and $50,000; and the reinsurance pool will pay 100 percent of the claims above $50,000. The structure of this reinsurance pool provides minimal incentives for insurers to manage the care provided to hospitalized patients, since virtually any hospitalization will result in claims topping $5,000. The reinsurance pool likely will inherit responsibility for a large part of health care spending. Studies suggest that a relatively small proportion of the population incurs a large proportion of health care expenditures, and so it is likely that most health expenditures will fall to this reinsurance pool.14

### Political Impetus For Reform

The Maryland health system reform bill builds on many of the recommendations made by the Governor’s Commission on Health Care Policy and Financing, which was established in 1988 to study several health policy issues, including coverage for the uninsured, cost containment, long-term care, simplified medical billing, and mandated benefits.

In the fall of 1990 the commission issued a detailed report on the uninsured in Maryland. The report addressed small-group health insurance market reform, a play-or-pay proposal based on employer tax incentives, and incremental expansions of public health insurance coverage for children and pregnant women.15 Subsequent reports included recommendations to simplify medical billing, establish a uniform summary explanation of medical benefits, and streamline health insurance paperwork. A final report described a proposal for systemic change and a universal health coverage program for Maryland, although this report was never approved by the governor’s commission. The commission also explored the feasibility of establishing a uniform statewide database that would integrate information on ambulatory services with the existing database on hospital services.

The commission reports sparked the interest of the Maryland General Assembly. This interest was further stimulated by a two-day health summit held in January 1992 that was organized by Democratic Governor William Donald Schaefer. The purpose of the summit was to allow members of the General Assembly and invited parties to review a wide range of health policy issues and reform proposals.

The General Assembly responded during the next legislative session by introducing several bills directed at small-market health insurance reform and long-term care insurance. In addition to the commission’s play-or-pay proposal, a Canadian-style universal health care proposal, small-group health reform, and a tax-based plan supported by Maryland Blue Cross/Blue Shield were introduced.16 Both legislative houses held hearings on health care reform in 1992. However, health care reform initiatives failed to advance beyond the committee level because of the General Assembly’s preoccupation with the state budget deficit.

Several events transpired over the following year that facilitated legislative action on health care reform. First, the General Assembly was able to focus on health issues...
in the 1993 session, since the state budget deficit was no longer a pressing issue. Second, the new Clinton administration publicly announced that national health system reform would be a major priority on its agenda. There was a feeling that the state should act to find solutions to its problems rather than waiting for the federal government to act. Many legislators, hospitals, and practitioners feared that a federally initiated program might not correspond with the state's reform goals.

Third, the solvency of Maryland Blue Cross/Blue Shield was subject to legislative scrutiny both nationally and in Maryland. The ensuing investigation worked to reinforce the view of many state legislators that regulation of the health insurance industry was a necessary component of health system reform. In addition, legislative testimony given by the Health Insurance Association of America (HIAA) contended that the economic impact of small-market reforms on premium increases would be much less than estimates provided by small carriers during the previous legislative session. Small carriers had testified that such reforms would drive premiums up 10-20 percent. However, based on findings from small-market reform enacted in Connecticut, the HIAA claimed that premium increases would be limited to less than 4 percent.

Fourth, testimony on the need for cost containment by the academic medical community and the Maryland Hospital Association overshadowed that of the state medical association during early debates. A new presence in the Maryland health policy debate was the incoming president of The Johns Hopkins Hospital and Health System, James Black, a strong advocate of community rating and of a regulatory and cooperative approach among providers.

Finally, the chairs of the pivotal House and Senate committees were able to mark up health care proposals to an undistracted General Assembly. Once the bill was presented to the General Assembly, the speaker of the House of Delegates provided critical leadership and actively supported the reform measures. In the end, the House and Senate committees found common ground in both small-employer health insurance reform and the need to address cost containment based on a regulatory framework. Both chairs used the consensus over small-group insurance reform to build coalitions to enact the final legislation.

Lessons From Maryland

The success of Maryland's health system reform may ultimately depend on the extent to which the federal government grants states the autonomy to implement their own health policies and programs and on the incentives that are provided to states under national reform. Certainly, the goals of the Maryland legislation are similar to those that the Clinton administration is hoping to achieve at a national level: increased access to care and cost containment.

In keeping with the HSCRC model Maryland has used to control hospital costs, many of the reform provisions are left to the new commission to develop and implement. The success of the reforms could depend more on the new commission than on any other factor. If the payment system, the data collection and reporting effort, and the provisions to achieve administrative efficiency in claims processing are successful, other states as well as the federal government should take notice of yet another Maryland innovation in health care based on a regulatory approach. The federal government could aid the commission by setting a reasonable rate of increase for expenditures. Maryland's federal waiver, which allows the state to maintain its rate-setting program, requires that the rate of hospital cost increases be held below Medicare increases.

Alternative to managed competition. At the federal level, managed competition has emerged as the preferred model of a reformed health care system. Managed competition may have limited applicability to states that lack a geographically diverse population necessary to sustain a sufficient number of independent provider groups to simulate a competitive market. A recent study of health care markets determined that provider groups practicing in areas
where the population is less than 360,000 would not be fully independent, and groups practicing where the population is less than 180,000 would be heavily dependent on each other. 19 Eight states have no cities with populations greater than 360,000, and five of those states lack cities with populations greater than 180,000. Only half of all states contain metropolitan statistical areas large enough to support three fully independent health plans. However, even these states have rural areas in which managed competition would be difficult to implement.

President Clinton has repeatedly expressed the opinion that states should be encouraged to take the lead in adopting health programs for their own populations. It is therefore likely that states would be able to opt out of any national reform plan, provided that they can demonstrate coverage for a certain proportion of the population and meet budget targets for overall health expenditures. Maryland’s regulatory approach to health care reform may be a potential alternative to a managed competition model for these states. If the Maryland reforms prove to be as successful at controlling overall health care costs as the state hospital rate-setting program has been, then it may be a model for other states as well.

The authors thank Michael Johns, Paul Hoffstein, Jon Saxton, Donna Imhoff, Arlene Stevenson, and Leah Wolfe for their helpful comments on earlier drafts.

NOTES

11. In an affirmative defense, the defendant can introduce the guideline as evidence of the standard of care. The plaintiff, however, can contest the reasonableness or appropriateness of the guideline.