SB 667

Department of Legislative Services

Maryland General Assembly
2014 Session

FISCAL AND POLICY NOTE

Senate Bill 667 (Senator Pinsky, *et al.*)
Finance

Maryland Health Benefit Exchange - Universal Health Care Program - Plan for Establishment

This bill requires the Board of Trustees of the Maryland Health Benefit Exchange (MHBE) to develop a plan for the State to establish a universal health care program, by January 1, 2017, to provide health benefits to all residents of the State through a single-payor system. The board must submit to the Governor and specified committees of the General Assembly (1) an interim progress report by October 1, 2014, and (2) the plan to establish the health care program by October 1, 2015.

The bill takes effect June 1, 2014.

Fiscal Summary

State Effect: Special fund expenditures for MHBE increase by $120,000 in FY 2015 and $30,000 in FY 2016 for contractual services to assist the board in developing the required plan. Any further impact depends on the plan developed and how and when it is to be implemented. No effect on revenues.

(in dollars)	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Revenues	$0	$0	$0	$0	$0
SF Expenditure	120,000	30,000	0	0	0
Net Effect	($120,000)	($30,000)	$0	$0	$0

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: The plan must include (1) a timeline for establishment of the health care program; (2) plans for transition to the program; (3) a proposed operating structure; (4) cost projections and recommendations for financing; (5) a proposed benefit package and an analysis of whether the program should include dental, vision, hearing, and long-term care benefits; and (6) recommendations for any required legislation.

The program must be designed to (1) provide comprehensive, affordable, and high-quality publicly financed health care coverage for all State residents; (2) include a benefit package covering primary care, preventive care, chronic care, acute care, and hospital services; (3) ensure that all federal payments provided for health services are paid directly to the program and assume responsibility for the benefits and services currently paid for and provided under State and federal programs; (4) include health care coverage provided by employers that choose to participate and to State, county, and municipal employees; and (5) contain costs. The board and the Department of Health and Mental Hygiene may apply for any federal waivers necessary to establish the program.

Current Law: The State provides comprehensive health care coverage through Medicaid and the Maryland Children's Health Program to eligible individuals. The State also has a variety of pharmacy assistance programs that assist lower-income individuals. The State provides comprehensive health care coverage to State employees, retirees, and their eligible dependents through the State Employee and Retiree Health and Welfare Benefits Program.

Background: The federal Patient Protection and Affordable Care Act (ACA) was enacted in 2010 to expand health care coverage, control health care costs, and improve the health care delivery system. Major features of the law include individual and employer mandates, expansion of Medicaid eligibility, creation of health benefit exchanges, premium and cost-sharing subsidies, and various changes to private insurance intended to make it easier to obtain insurance and protect patients.

Section 1332 of ACA allows states to request five-year waivers of certain key provisions of health reform. Provisions that can be waived include qualified health plans (including the essential health benefits package), the health insurance exchanges, premium tax credits, cost-sharing reduction payments, the individual mandate, and the employer responsibility requirements. If a state is granted a waiver, it can fund its reforms through the aggregate amount of federal funding that otherwise would have been paid out within the state for premium tax credits, cost-reduction payments, and small business tax credits. To be approved, a waiver for state innovation must cover at least as many people as under ACA and provide coverage that is at least as comprehensive and affordable, at no

greater cost to the federal government. The Secretary of Health and Human Services and the Secretary of the Treasury have joint responsibility for approving waivers, which cannot take effect until January 1, 2017.

In May 2011, Vermont was the first state to enact legislation to establish a universal, unified, publicly financed single-payor health care system that covers all state residents. The system, Unified Green Mountain Care, will be based on the Vermont Health Benefit Exchange and is intended to encourage efficiency, lower overhead costs, and incentivize health outcomes. The program will not require residents to drop existing private coverage, nor does it prohibit them from purchasing supplemental coverage if desired.

Also under ACA, Maryland is 1 of 25 states to receive a State Innovation Models (SIM) grant. Maryland will use the grant to develop the new Community-Integrated Medical Home initiative. Through this program, primary care providers will lead a team of health professionals focused on coordinating personalized care that meets the complex needs of patients. Community-Integrated Medical Homes will engage with enhanced local health improvement coalitions, which will offer complementary supports to high-risk patients, identify and respond to hot spots of health needs, and monitor community and population health.

State Expenditures: Special fund expenditures increase by $120,000 in fiscal 2015, which accounts for a one-month start-up delay. Due to the complexity of establishing a plan for a universal, single-payor health care system, contractual services are required. This estimate reflects the cost of hiring a contractor to assist the board in developing a plan to establish a universal health care program. It is assumed that total contractual expenditures will be $150,000, with $120,000 paid in fiscal 2015, and the remaining $20,000 paid in fiscal 2016 upon completion of the plan and submission to the Governor and the General Assembly.

Additional Comments: Several bills have been introduced in recent years to establish a comprehensive single-payor health care system. SB 206 of 2012, SB 388 of 2011, and SB 682 of 2010 received unfavorable reports from the Senate Finance Committee. SB 881 of 2009 received a hearing in the Senate Finance Committee, but no further action was taken. HB 1015 of 2012 received a hearing from the House Health and Government Operations Committee but was withdrawn. HB 1035 of 2011 received a hearing from the House Health and Government Operations Committee, but no further action was taken. HB 767 of 2010 received an unfavorable report from the House Health and Government Operations Committee. HB 1186 of 2009 received a hearing in the House Health and Government Operations Committee, but no further action was taken.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Vermont Agency of Administration, Department of Budget and Management, Department of Health and Mental Hygiene, Maryland Insurance Administration, Department of Legislative Services

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mc/ljm

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