HB 660

Department of Legislative Services

Maryland General Assembly
2018 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 660 (Delegate Reznik)
Health and Government Operations and Economic Matters

Public Health - State-Provided Health Care Benefits for State Residents (HealthcareMaryland)

This bill creates an Office of Health Care Coverage within the Maryland Department of Health (MDH) to establish and carry out a new HealthcareMaryland program. A Health Care Coverage Fund is also established to provide coverage to eligible State residents through the program, which is funded in part by a 10% payroll tax. A HeathcareMaryland Commission must provide recommendations for implementation of the program. **Provisions relating to the new commission take effect July 1, 2018, and terminate June 30, 2021; all other provisions take effect July 1, 2020.**

Fiscal Summary

State Effect: Special fund revenues increase by a significant but indeterminate amount beginning in FY 2021 from the payroll tax and appropriations to the fund. Special fund expenditures increase by $31.0 million beginning in FY 2021 to collect the payroll tax and implement the HealthcareMaryland enrollment system only. Special fund expenditures further increase by a significant but indeterminate amount beginning in FY 2021 to implement the program.

Local Effect: Local governments that purchase fully insured health plans are subject to the payroll tax. **This bill imposes a mandate on a unit of local government.**

Small Business Effect: Meaningful.

Analysis

Bill Summary:

Office of Health Care Coverage

Beginning July 1, 2020, the Office of Health Care Coverage is established in MDH and is required to (1) enroll in HealthcareMaryland all State residents who do not receive federal benefits through Medicare, TRICARE, plans that are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA), or any other federal medical program; (2) contract with managed care organizations (MCOs) to provide program benefits; (3) determine reimbursement rates for MCOs and health providers; (4) determine the health care benefits and services that will be covered under the program; (5) establish and maintain a preferred prescription drug list and negotiate pharmaceutical costs; (6) adjudicate service and fee denial appeals; (7) administer the Health Care Coverage Fund; and (8) collaborate with the Treasurer to disburse payments for the fund.

Any health care provider licensed in Maryland may participate in the program. An MCO may determine the providers who participate in the MCO's network. An MCO participating in the program must maintain a network of providers for serving enrollees that is able to meet geographic requirements determined by the commission. A participating MCO must provide an essential benefits package that is equal to or more comprehensive than the benefits provided under the federal Patient Protection and Affordable Care Act (ACA) and includes specified benefits and any other benefits determined by the commission.

An MCO participating in the program may require cost sharing by enrollees, including copayments and deductibles, in accordance with regulations adopted by the program. The cost sharing must be scaled according to an individual's income tax bracket. An individual in the lowest income tax bracket may not be subject to cost sharing.

The office must pay an MCO a capitated rate for each enrollee based on the actuarial cost of the MCO's benefits, costs, and usage.

The office must collaborate with the Motor Vehicle Administration (MVA) to (1) identify State residents who are eligible for the program using the driver's license database and (2) contact eligible State residents and provide an opportunity to enroll with an MCO. A State resident who does not enroll with an MCO must be auto-enrolled in a manner that ensures equitable distribution of enrollees among participating MCOs.

The office must collaborate with the Maryland Health Benefit Exchange (MHBE) to enroll State residents in the program and ensure the availability of a web-based program for

enrollment that is located in health care facilities and offices and accessible by a State resident who does not have a driver's license or State-issued identification card.

Health Care Coverage Fund

Beginning July 1, 2020, a Health Care Coverage Fund is established. The purpose of the fund is to provide health care coverage to eligible State residents through the program. The fund is a special, nonlapsing fund not subject to specified provisions of the State Finance and Procurement Article and administered by MDH. The fund consists of:

- money appropriated in the State budget to the fund in an amount at least equal to the annual cost of State personnel health insurance costs as of 2017;
- any revenue received from the payroll tax imposed under the bill;
- any funds available to the State resulting from savings achieved through streamlining, consolidating, or eliminating commissions, programs, or other units of State or local government in establishing the program;
- any savings achieved by the State as a purchaser of pharmaceuticals or through negotiated reimbursement rates;
- interest earnings of the fund; and
- any other money from any other source accepted for the benefit of the fund.

The fund may be used only for any costs associated with the office and carrying out the program, including any administrative expenses. The office must adopt regulations to implement the fund.

Payroll Tax

Beginning July 1, 2020, each "employer" (excluding the federal government or another state) is required to pay to the Secretary of Labor, Licensing, and Regulation an annual payroll tax equal to 10% of the total wages paid to its employees in the State during the immediately preceding calendar year. When calculating the payroll tax payment, an employer may exempt (1) wages paid beyond the amount taxable for federal Social Security (FICA) purposes and (2) wages paid to an employee who is enrolled in or eligible for Medicare or receives federal benefits through TRICARE, plans subject to ERISA, or any other federal medical program.

An employer must pay the payroll tax to the Secretary on a periodic basis and submit periodic reports for the determination of the payroll tax due as required by the Secretary in regulations. An employer may not deduct the payroll tax, wholly or partly, from the wages of an employee.

HealthcareMaryland Commission

Beginning July 1, 2018, a 15-member HealthcareMaryland Commission is established. MDH must provide staff for the commission. A member of the commission may not receive compensation but is entitled to reimbursement for expenses under the standard State travel regulations, as provided in the State budget.

The commission must provide recommendations for implementation of the HealthcareMaryland Program, including the financing, benefit package, rate structure, enrollment criteria, and provider requirements. The commission must establish subcommittees to address (1) financing; (2) benefits; (3) rates and reimbursements; (4) enrollment and provider criteria; and (5) program design. Each subcommittee must address specified topics related to the establishment and operation of the program.

By July 1, 2019, the subcommittees must report specified findings and recommendations to the commission. By December 1, 2019, the commission must report to the Governor and the General Assembly on regulatory and legislative recommendations to (1) implement the HealthcareMaryland program and (2) establish a permanent HealthcareMaryland Commission. The commission terminates June 30, 2021.

Current Law/Background: The State provides comprehensive health care coverage through Medicaid and the Maryland Children's Health Program (MCHP) to eligible individuals. The State also provides comprehensive health care coverage to State employees, retirees, and their eligible dependents through the State Employee and Retiree Health and Welfare Benefits Program.

Medicaid and the Maryland Children's Health Program

Medicaid generally covers children, pregnant women, elderly or disabled individuals, low-income parents, and childless adults. To qualify for Medicaid, applicants must pass certain income and asset tests. Effective January 1, 2014, Medicaid coverage was expanded to persons with household incomes up to 138% of federal poverty guidelines (FPG), as authorized under the ACA. MCHP is Maryland's name for medical assistance for low-income children. MCHP provides all the same services as Medicaid. A premium of about 2% of family income is required of child participants with family incomes above 200% FPG. In fiscal 2018, there are 1.2 million individuals enrolled in Medicaid and approximately 146,400 children enrolled in MCHP.

The Federal Patient Protection and Affordable Care Act

The ACA requires nongrandfathered health plans to cover 10 essential health benefits (EHBs), which include items and services in the following categories: (1) ambulatory

patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including dental and vision care.

Under § 31-116 of the Maryland Insurance Article, EHBs must be included in the State benchmark plan and, *not withstanding any other benefits mandated by State law*, must be the benefits required in (1) all individual health benefit plans and health benefit plans offered to small employers (except for grandfathered health plans) offered outside MHBE and (2) all qualified health plans offered in MHBE.

Employee Retirement and Income Security Act of 1974

ERISA contains a preemption clause stating that the Act "shall supersede any and all state laws insofar as they relate to any employee benefit plan." These benefits include health care. State reforms have often come into conflict with ERISA when they relate, directly or indirectly, to employee benefits. States cannot mandate that employers pay for health insurance, directly tax benefit plans, impose significant costs on plans, dictate the terms of an ERISA plan, or require reports on cost or use of the plans from employers. States are permitted to "regulate the business of insurance." A self-funded plan may not be regulated as insurance as ERISA specifies it is not an insurance plan.

Single-payer Proposals in Other States

In May 2011, Vermont became the first state to enact legislation to establish a universal, unified, publicly financed single-payer health care system that covers all state residents. The system, Green Mountain Care, was intended to encourage efficiency, lower overhead costs, and incentivize health outcomes. However, in 2014, the state abandoned its plans to implement the program due to administrative and financing issues.

In May 2017, the New York State Assembly passed a bill that would provide universal statewide coverage throughout the state with no out-of-pocket costs or network restrictions. Identified funding sources would be $90 billion in progressive payroll taxes and/or non-earned income tax increases. The bill did not pass the New York State Senate.

In June 2017, the California State Senate passed a bill to create Healthy California, a single health care market for everyone without premiums, copayments, or deductibles. Medical, pharmaceutical, dental, vision, and long-term care services would be provided to all residents (including undocumented immigrants) free of charge. The state would seek to pay providers Medicare rates, and a nine-person panel would administer the program. The bill, which is on hold in the California Assembly, is estimated to cost $400 billion per year

and would be funded with $200 billion outside current state and federal spending, a 15% payroll tax, and a 2.3% sales tax.

State Revenues:

Payroll Tax

The bill requires each employer, beginning July 1, 2020 (fiscal 2021) to pay an annual payroll tax equal to 10% of the total wages paid to employees in the State during the immediately preceding calendar year. An employer may exempt (1) wages paid beyond the amount taxable for federal Social Security (FICA) purposes and (2) wages paid to an employee who is enrolled in or eligible for Medicare or receives federal benefits through TRICARE, plans subject to ERISA, or any other federal medical program.

Based on calendar 2016 data from the Quarterly Census of Employment and Wages and assuming 2% annual growth in wages, estimated total annual wages in Maryland in 2021 will be $152.5 billion. This figure excludes wages paid by the federal government. Based on this estimated wage base, a 10% payroll tax could generate *as much as* $15.3 billion in revenues in fiscal 2021. However, this figure will be reduced (potentially significantly) based on exemptions for wages above the FICA base. The taxable wage base for 2018 FICA purposes is $128,400 per employee, which would result in a maximum tax of up to $12,840 per employee. Actual revenues will be further reduced by exemptions for income earned by individuals eligible for or enrolled in Medicare or receiving benefits through TRICARE, ERISA plans, or any other federal medical program.

Health Care Coverage Fund

In addition to any revenue received from the payroll tax, as discussed above, the fund consists of money appropriated in the State budget in an amount equal to the annual cost of State personnel health insurance costs as of 2017. The total costs for personnel administration, medical claims, prescription claims, dental, and contractual employee claims in fiscal 2017 for the State Employee and Retiree Health and Welfare Benefits Program was $1,511,900,000. Thus, revenues to the fund increase by *at least* $1.5 billion in fiscal 2021.

The fund also consists of specified savings achieved through streamlining, consolidating, or eliminating commissions, programs, or other units of State or local government, and savings achieved by the State as a purchaser of pharmaceuticals or through negotiated reimbursement rates. The amount of any such savings cannot be reliably estimated at this time and are, therefore, not reflected in this analysis.

Other Impacts

This analysis assumes that, under the HealthcareMaryland program, MHBE's Individual and Small Business Health Options exchanges will cease to operate and individuals currently covered through MHBE will be enrolled in the program. The Department of Legislative Services (DLS) notes that, in calendar 2018, 121,400 individuals enrolled in MHBE are eligible to receive federal advanced premium tax credits (APTCs) to offset the costs of their insurance premiums. The monthly value of APTCs to Maryland residents in January 2018 alone was $63.9 million. These tax credits will no longer be available to Marylanders under the bill; however, individuals will also not be required to purchase plans on their own. Maryland may be able to seek a federal waiver to retain this funding.

State Expenditures: This analysis assumes the following timeline for implementation:

- In fiscal 2019, the HealthcareMaryland Commission and its subcommittees develop recommendations for the financing, benefit package, rate structure, enrollment criteria, and provider requirements for the program.

- In fiscal 2020, the commission reports its regulatory and legislative recommendations to implement the program to the Governor and the General Assembly.

- In fiscal 2021, the Department of Labor, Licensing, and Regulation (DLLR) begins collection of a payroll tax, MDH creates an Office of Health Care Coverage, and the office and MHBE begin implementation of the HealthcareMaryland program, with coverage beginning January 1, 2021.

HealthcareMaryland Commission

MDH advises that it can staff the commission and its five subcommittees; prepare the subcommittees' findings and recommendations for presentation to the commission by July 1, 2019; and prepare and submit the required report to the Governor and the General Assembly by December 1, 2019, using existing budgeted resources.

Payroll Tax

To administer the new payroll tax, DLLR must establish a new payroll tax unit. Based on the personnel required to operate DLLR's existing unemployment insurance (UI) contribution tax units (which are federally funded and cannot be used to collect and administer a program other than UI), DLLR advises that approximately 114 new employees are required for the new unit. In addition to hiring and training personnel, a payroll tax

unit would require significant new information technology (including creation of a tax database) and the leasing of office space, among other costs.

DLLR expenditures increase by $29.7 million in fiscal 2021, which accounts for the July 1, 2020 effective date. This estimate reflects the cost of hiring approximately 114 employees to administer a payroll tax and the first of four years of contractual information technology expenses ($20.0 million a year for a total of $80.0 million) to create the tax database. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Positions	114
Information Technology Contract	$20,000,000
Salaries and Fringe Benefits	8,756,424
Rental Space	285,000
One-time Start-up Costs	557,460
Ongoing Operating Expenses	71,250
DLLR FY 2021 State Expenditures	**$29,670,134**

As the Health Care Coverage Fund, which includes revenues from the payroll tax, can be used for any costs associated with the office and carrying out the program, including any administrative expense, this estimate assumes that special fund expenditures are used to support the payroll tax unit.

Future year expenditures reflect full salaries with annual increases and employee turnover and ongoing operating expenses. Contractual information technology costs of $20.0 million continue annually through fiscal 2024.

Office of Health Care Coverage

The office must enroll in the program all Maryland residents who do not receive federal benefits through Medicare, TRICARE, plans that are subject to ERISA (self-funded employer health plans), or any other federal medical program. The office must collaborate with MHBE to enroll State residents in the program and ensure the availability of a web-based program for enrollment. As MHBE currently provides enrollment assistance through Maryland Health Connection for exchange enrollees and some Medicaid and MCHP enrollees, this analysis assumes that MHBE develops and implements a system for enrollment.

Thus, MHBE special fund expenditures increase by an estimated $1.4 million in fiscal 2021, which accounts for the July 1, 2020 effective date of the bill's provisions establishing the office and the program. To develop the system, MHBE anticipates hiring at least 10 new staff (some contractual and some permanent, including a program manager,

project manager, database management specialist, applications development expert, senior applications architect, testing specialist, subject matter expert, security specialist, network manager, and electronic data interchange specialist). Ongoing costs to maintain and operate the program are estimated to cost approximately $577,500 annually.

MVA advises that it can work with the office to provide data regarding eligible State residents through data sharing agreements within existing budgeted resources.

HealthcareMaryland Program

As the specifics regarding financing, benefits, eligibility, enrollment and provider criteria, and program design for HealthcareMaryland will be determined based on the findings and recommendations of the commission, the cost to implement the program cannot be reliably estimated at this time.

For illustrative purposes only, total personal health care spending in Maryland for 2018 is projected to be $59.3 billion. Of this spending, $29.9 billion (50.4%) is attributable to federal health programs including Medicare ($13.1 billion), Medicaid ($12.3 billion), the Federal Employees Health Benefits Program ($2.1 billion), the Veterans Administration ($1.2 billion), and TRICARE ($1.2 billion). More than 3 million Marylanders received their health care coverage through these programs in 2017. Beyond these costs, additional costs would be incurred to provide full coverage to those who are currently uninsured (an estimated 389,000 Marylanders in 2017) and underinsured (as many as 34% of insured individuals).

DLS notes that, under a single-payer system, there are likely to be both structural and systemic savings through consolidated administration, government negotiated rates with providers and pharmaceutical manufacturers, and a reduction in unnecessary services, service delivery inefficiencies, missed prevention opportunities, and fraud. Other analyses of single-payer proposals have estimated such savings at as much as 18%. However, DLS advises that Maryland's Health Services Cost Review Commission already regulates hospital rates, which account for 38.7% of total health care spending in 2018. Thus, Maryland would likely not achieve as much savings as estimated in other states. Furthermore, any potential savings likely accrue over the long term rather than the short term.

Local Fiscal Effect: The Office of the Comptroller advises that local governments that are not subject to ERISA are negatively impacted by the payroll tax requirement.

Small Business Effect: Small businesses that are not subject to ERISA are negatively impacted by the payroll tax requirement.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): U.S. Department of Health and Human Services; *Health Affairs*; Comptroller's Office; Department of Budget and Management; Maryland Department of Health; Department of Labor, Licensing, and Regulation; Maryland Department of Transportation; Health Benefit Exchange; Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - March 4, 2018
mm/ljm

Analysis by: Jennifer B. Chasse and Nathan W. McCurdy

Direct Inquiries to:
(410) 946-5510
(301) 970-5510