HB 1035

Department of Legislative Services

Maryland General Assembly
2011 Session

FISCAL AND POLICY NOTE

House Bill 1035 (Delegate Carter, *et al.*)
Health and Government Operations

Maryland Health Security Act of 2011

This bill establishes a single-payor Maryland Health System to (1) provide comprehensive and coordinated health care coverage that is not dependent on employment to all State residents; (2) reduce costs; and (3) establish mechanisms to reduce medical errors, decrease health disparities, resolve provider shortages, and ensure transparency and accountability.

The bill's provisions regarding the Maryland Health System take effect July 1, 2013, while the remainder of the bill's provisions relating to various boards to transition to and implement the system take effect October 1, 2011.

Fiscal Summary

State Effect: Potentially significant expenditure reductions for the Department of Health and Mental Hygiene (DHMH), the Maryland Insurance Administration, the Maryland Health Insurance Plan (MHIP), and the State Employee and Retiree Health and Welfare Benefits Plan (State plan) beginning in FY 2014. The proposed FY 2012 State budget includes more than $9.8 billion for health care. Significant revenues and expenditures for the Maryland Health System Trust Fund beginning in FY 2014. In 2007, Maryland residents spent nearly $36 billion on health care costs. Significant reduction in uncompensated health care costs in Maryland.

Local Effect: Potentially significant reduction in local health department expenditures as well as local jurisdiction employee benefit expenditures.

Small Business Effect: Meaningful. Small businesses may benefit from significant expenditure reductions for employee health insurance. Small business health care providers may experience increased or decreased reimbursements, depending on reimbursement rates set by the Maryland Health System Payment Board.

Analysis

Bill Summary: Each State resident is a member of the plan and is eligible to receive benefits for services covered under the plan. A health insurer, nonprofit health service plan, or health maintenance organization may offer benefits that do not duplicate services covered by the plan. Highlights of the system for enrollees include no preexisting condition limitations, coinsurance, deductibles, or copayments as well as choice of provider.

A Maryland Health System Trust Fund is established to finance the single-payor system and an Office of the Health Inspector General is created to audit payments and investigate complaints about the Health System. The special, nonlapsing fund consists primarily of (1) money from State and federal financial participation in Medicaid, the Maryland Children's Health Program (MCHP), and Medicare; (2) money from other federal programs that pay for health care services; and (3) State and local funds appropriated for health care services.

Seven boards are established to administer and oversee the Health System, with specific duties, membership requirements, and term provisions, including the:

- *Maryland Health System Policy Board* to establish a benefits package and global budget, ensure adequate funding, evaluate requests for capital expenses, evaluate performance, help ensure public feedback, develop standards of care, develop a plan to ensure adequate distribution of providers, and oversee other boards; and the Office of the Health Inspector General;
- *Maryland Health System Administrative Board* to plan for and oversee the transition to the Health System, implement specific plans to decrease administrative costs, and administer payments and a statewide system of electronic medical records;
- *Maryland Health System Health Needs, Planning, and Improvement Board* to recommend services, review requests for services not covered, develop a proposal for long-term care coverage for the Health System by October 1, 2016, develop a health database and a comprehensive system of community health centers, engage in health promotion, and approve grants to local communities;
- *Maryland Health System Quality Board* to establish clinical standards, a prescription drug formulary, guidelines for prescribing, medical error programs, guidelines for care coordination, and programs to monitor adherence to best practices of care;
- *Maryland Health System Patient Advocacy Board* to advocate for and educate residents regarding the Health System, prepare materials on member benefits and rights, establish a grievance system, and create a Public Advisory Committee;

- *Maryland Health System Fund Board* to manage the fund, establish a sufficient reserve account, and recommend funding sources; and
- *Maryland Health System Payment Board* to establish and negotiate payment rates, negotiate discounts for prescription drugs and medical equipment, and provide incentives to attract health care professionals into needed practice fields and geographical areas.

Members of all boards may not be employed by and may not have been employed within the two-year period immediately preceding appointment by pharmaceutical companies, medical equipment companies, or for-profit insurance companies; nor may they accept employment with such companies for two years following the end of their terms.

By October 1, 2012, DHMH must apply for federal waivers to permit the State to deposit all federal payments under State health care programs to the Maryland Health System Fund. Also by this date, the Maryland Health System Policy Board must seek all waivers from the federal Employee Retirement Income Security Act (ERISA) necessary to ensure total participation in the Health System and must report on any legislative changes necessary to most effectively carry out the provisions of the bill.

Current Law: There is no universal health care delivery system. The State provides comprehensive health care coverage through Medicaid and MCHP 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 plan.

Medicaid and the Maryland Children's Health Program: Medicaid provides health care coverage to children, pregnant women, elderly or disabled individuals, and indigent parents who pass certain income and asset tests. Eligibility for MCHP currently extends to individuals younger than age 19 with family incomes up to 300% of the federal poverty guidelines (FPG). Children in families with incomes above 200% but at or below 300% FPG are enrolled in the MCHP Premium Plan. Individuals who have been eligible for employer-sponsored health insurance in the previous six months are ineligible for MCHP. Children and pregnant women who have not been legal immigrants for at least five years are ineligible for federal Medicaid and MCHP benefits. The State currently provides Medicaid benefits to legal immigrant pregnant women and children who have been in the country for less than five years using general funds only. Emergency services are provided to all financially eligible individuals regardless of immigration status.

Chapter 7 of the 2007 Special Session: Chapter 7 expanded eligibility for Medicaid to parents, caretaker relatives, and childless adults with incomes up to 116% FPG.

Chapter 7 also established a Small Employer Health Benefit Plan Premium Subsidy Program and the Health Care Coverage Fund.

Maryland Health Insurance Plan: MHIP provides health care coverage for individuals who have certain qualifying conditions or do not have access to health insurance. Members are required to pay a premium based on age, subscriber type, and type of benefit plan. Individuals with incomes below 300% FPG may receive discounted premiums through MHIP+.

Background:

Health Care Spending in Maryland: In 2007, Maryland residents spent $35.8 billion for health care services, averaging $6,374 per person. Total health care spending as well as per capita spending increased 6% from 2006 to 2007, approximately equal to the national average.

Nearly one-third of Maryland's health care dollars was spent on hospital care (approximately $11.6 billion). Inpatient hospital care accounted for 24% ($8.6 billion) of total health care dollars spent; outpatient hospital care accounted for 8% ($3.0 billion). Physician and other professional services accounted for another 30% of health care spending, with 17% ($6.2 billion) spent for physician services, and 13% ($4.6 billion) spent for other professional services. Spending for outpatient prescription drugs was 16% of total health care spending, totaling $5.6 billion. Nursing home, home health, and other services accounted for 13% of health care spending ($4.6 billion), and the administrative costs of health insurance accounted for 9% of total health care spending ($3.1 billion).

In 2007, private insurance accounted for the largest proportion of total health care spending in Maryland at 39%, while Medicare (which covers seniors and specified individuals with disabilities) accounted for 23% of total health care spending. Medicaid (which covers specified low-income individuals) accounted for 16% of the total expenditures for health care in the State. Marylanders paid 19% of the cost of health care − $6.6 billion – out of pocket. The remainder was covered by various other small government programs.

Uninsured in Maryland: According to the Maryland Health Care Commission, in 2008-2009, 14.5% of Maryland's noneldery population was uninsured, with an average of 720,000 uninsured nonelderly residents per year.

Single-payor Health Care: Many other countries have single-payor health care systems, including Canada and Australia. Several states have also considered single-payor systems, including California, Illinois, Massachusetts, and Oregon.

Federal Health Care Reform: In March 2010, major federal health care reform legislation (the Patient Protection and Affordable Care Act or ACA) was enacted 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 to 133% FPG, 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.

Health Care Reform in Other States: To date, only three states (Massachusetts, Vermont, and Maine) have enacted comprehensive health care reform proposals aimed at achieving near universal coverage of residents. These reforms have included such policies as individual and employer mandates and subsidized insurance plans. Approaches to reform have varied in other states, but most states, like Maryland, have taken an incremental approach such as expansion of Medicaid and Children's Health Insurance Programs and insurance market reforms.

ERISA: The federal Employee Retirement and Income Security Act of 1974 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, or require reports on cost or use of the plans from employers. States are permitted to "regulate the business of insurance."

State Fiscal Effect: There are insufficient data to reliably estimate the potential impact to the State. The bill calls for most health programs to be incorporated into the Maryland Health System. Such a transfer will take a significant amount of time and planning and will in all likelihood be phased in over time. DHMH expenditures for Medicaid and other health care programs decrease significantly as covered populations are transferred into the plan. As a point of reference, the following programs are projected to spend approximately $9.8 billion in fiscal 2012.

Public Health Program	**Fiscal 2012 Proposed Budget**
Medicaid	$7.1 billion
Mental Hygiene Administration	1.0 billion
Developmental Disabilities Administration	832.4 million
Infectious Disease, Environmental Health, Family Health	379.1 million
Maryland Health Insurance Plan	282.9 million
Alcohol and Drug Abuse Administration	150.4 million
Total	**$9.8 billion**

Depending on the benefits package developed by the Maryland Health System Policy Board, additional health care funds may be transferred to the trust fund as well, including funds appropriated under the AIDS Administration.

Additionally, State plan expenditures will decrease significantly. The State plan, which provides comprehensive health benefits coverage to State employees and retirees, will be cut back significantly, providing only benefits such as term life insurance. For fiscal 2012, the State plan is projected to spend $1.259 billion on payments to health care providers.

Additional Information

Prior Introductions: SB 682 and HB 767 of 2010 received unfavorable reports from the Senate Finance and House Health and Government Operations committees, respectively. SB 881 of 2009 received a hearing in the Senate Finance Committee, but no further action was taken. Its nonidentical cross file, HB 1186, received a hearing in the House Health and Government Operations Committee, but no further action was taken. Several other bills have been introduced in recent legislative sessions to establish a universal health care system in Maryland.

Cross File: None.

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

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