SB 228

Department of Legislative Services

Maryland General Assembly
2020 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 228 (Senator Pinsky)
Finance

Public Health - Commission on Universal Health Care

This bill establishes the Commission on Universal Health Care to develop a plan for the State to establish, by January 1, 2023, a universal health care program to provide health benefits to all residents of the State through a single-payer system. The commission must submit (1) by October 1, 2020, an interim progress report on the development of a plan and (2) by October 1, 2021, the plan to establish the health care system. The Maryland Department of Health (MDH) must provide staff for the commission. **The bill takes effect June 1, 2020, and terminates June 30, 2024.**

Fiscal Summary

State Effect: No effect in FY 2020. MDH general fund expenditures increase by *at least* $3.3 million in FY 2021 to staff the commission, hire consultants, and prepare the plan. Future years reflect additional consulting costs in FY 2022, ongoing expenditures, and termination of the contractual positions in FY 2024. Revenues are not affected.

(in dollars)	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Revenues	$0	$0	$0	$0	$0
GF Expenditure	3,324,100	905,000	107,900	111,500	0
Net Effect	($3,324,100)	($905,000)	($107,900)	($111,500)	$0

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

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary:

Commission on Universal Health Care

The commission consists of (1) the Secretary of Health (or the Secretary's designee), as an *ex officio* member; (2) four members appointed by the Governor, with the advice and consent of the Senate; (3) three members appointed by the President of the Senate; and (4) three members appointed by the Speaker of the House. The bill establishes extensive procedures and criteria for the selection and appointment of commission members. A member of the commission may not receive compensation but is entitled to a per diem rate and reimbursement for expenses, as provided in the State budget. A member of the commission must adhere strictly to conflict-of-interest provisions.

Universal Health Care Program

The health care program must be designed to (1) provide comprehensive, affordable, and high-quality publicly financed health care coverage for all residents of the State; (2) include a benefit package covering primary care, preventive care, chronic care, acute episodic care, and hospital services; (3) ensure that all federal payments provided in the State are paid directly to the program and assume responsibility for the benefits and services currently paid for and provided under specified 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 as specified.

The commission, the Maryland Health Benefit Exchange (MHBE), and MDH may apply for waivers of requirements of health care programs under federal law that are necessary to establish the program.

Required Plan

The plan must include (1) a timeline for the establishment of the program; (2) specified plans for transition to the program; (3) a proposed operating structure; (4) cost projections and recommendations for financing; (5) a proposed health benefit package to be offered in the program and an analysis of whether the program should include specified benefits; and (6) recommendations for legislation required to establish the program.

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 federal Patient Protection and Affordable Care Act (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. As of January 2020, there were 1,248,216 individuals enrolled in Medicaid and 138,717 children enrolled in MCHP in Maryland.

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.

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 bill, estimated to cost $330 billion to $400 billion per year, would have been funded with $200 billion outside current state and federal spending, a 15% payroll tax, and a 2.3% sales tax.

Healthy California for All Commission

In December 2019, California Governor Gavin Newsom announced the launch of the Healthy California for All Commission to develop a plan for "advancing progress toward achieving a health care delivery system for California that provides coverage and access through a unified financing system." The commission will prepare an initial report for the California legislature by July 2020, and a final report by February 2021. The first commission meeting was held in January 2020.

State Expenditures: The bill requires the commission, which is established June 1, 2020, to submit an interim progress report by October 1, 2020, and just one year later, by October 1, 2021, a plan for the State to establish a single-payer universal health care program by January 1, 2023. The commission terminates June 30, 2024.

Given the short 16-month timeframe required for the commission to develop and submit the plan and the complexity of the plan's required components, general fund expenditures increase by *at least* $3.3 million in fiscal 2021, which accounts for a 30-day start-delay from the bill's June 1, 2020 effective date. This estimate reflects the cost of hiring two full-time contractual positions (one program manager and one administrator) to staff and support the commission and the cost to hire a consultant to conduct the required cost analysis and assist the commission in developing the required plan. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses. It does not reflect commission-related administrative costs such as printing, mailing, or per diem or mileage reimbursement for members. Based on MDH's costs for the most recent Medicaid § 1115 waiver renewal application and the significant complexity and scope of the commission's work, consultant costs are estimated to be approximately $4.0 million (assumed to be incurred as $3.2 million in expenditures in fiscal 2021 and $800,000 in expenditures in fiscal 2022).

Contractual Positions	2
Consultant Costs (Minimum)	$3,200,000
Salaries and Fringe Benefits	113,085
One-time Start-up Expenses	9,780
Ongoing Operating Expenses	1,270
Total FY 2021 State Expenditures	**$3,324,135**

Future year expenditures reflect full salaries with annual increases and employee turnover and ongoing operating expenses for continued staffing of the commission. The two contractual positions terminate at the end of fiscal 2024.

This estimate does not include any health insurance costs that could be incurred for specified contractual employees under the State's implementation of the ACA.

Furthermore, the estimate does not reflect the potential cost of any waiver applications necessary to establish the program nor any fiscal impact related to the implementation of the plan.

Additional Information

Prior Introductions: None.

Designated Cross File: None.

Information Source(s): Department of Budget and Management; Maryland Department of Health; Maryland Health Benefit Exchange; Maryland Insurance Administration; Department of Legislative Services

Fiscal Note History: First Reader - February 17, 2020
an/ljm

Analysis by: Jennifer B. Chasse

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