Sheila Ruth
Legislative District 44B
Baltimore County

Environment and Transportation
Committee

Annapolis Office
The Maryland House of Delegates
6 Bladen Street, Room 311
Annapolis, Maryland 21401
410-841-3802 · 301-858-3802
800-492-7122 *Ext.* 3802
Sheila.Ruth@house.state.md.us

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

Sponsor Testimony in Support of HB470

Public Health - Commission on Universal Health Care

Delegate Sheila Ruth

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HB470 establishes a Commission on Universal Healthcare to study the creation of a statewide, single-payer, universal healthcare system and develop a plan for the State to establish it by January 1, 2024

The Affordable Care Act made strides in closing the health care coverage gap, however, many people still remain uninsured. 355,000 Marylanders were uninsured as of March, 2019, and that was before the pandemic.

Around 900,000 Marylanders filed for unemployment during first year of COVID-19. Some of those certainly lost employer-based health insurance, in the middle of a pandemic.

Maryland opened special enrollment on the health benefit exchange, but the costs of the exchange are out of reach for many. Some of the cheapest plans have deductibles of $6000 or more, meaning that they can't be used except for catastrophic health events, and even then a person may delay care due to inability to afford out of pocket expenses

Everyone should have a right to healthcare when and where they need it, regardless of race, ethnicity, zip code, economic status, or disability.

No state has yet enacted a statewide universal healthcare plan, but there are good reasons to be optimistic that it can be done, and Maryland has the opportunity to be a leader.

Canada first enacted universal healthcare in province of Saskatchewan. The Saskatchewan model was later adopted nationally.

U.S. healthcare has some unique factors that will make statewide single-payer healthcare challenging, including Medicare, Medicaid, federal employee health programs, worker's compensation, and the federal Employee Retirement Income Security Act of 1974 (ERISA), which prohibits states from dictating employer health care benefits.

However, much work has already been done in these areas nationally and in other states, and there are reasons to believe that most of these barriers can be overcome. A pure single-payer

state health plan is probably not possible without a change in federal laws, however, by careful coordination of the state plan with Medicare, Medicaid, and other federal programs, it should be possible to develop a plan that provides the same comprehensive level of care at close to the same cost savings.

The Affordable Care Act allows for states to apply for a state innovation waiver of all ACA requirements, as long as the state plan provides at least as much coverage as the ACA, and doesn't impose extra costs on the federal government.

These requirements should easily be achievable with a single-payer universal healthcare system due to administrative cost savings and market share savings. Medicare currently only spends about 2% on administrative costs, compared to private insurance with 12% administrative costs.

The Congressional Budget Office released an analysis of Medicare for All in December. They analyzed five different possible scenarios. In four of those, overall health care costs dropped significantly. The fifth scenario included a large expansion of long term services and supports for people with disabilities. With this addition, the overall costs would be greater than today's costs, but only by $290 billion, which isn't a lot to close this important health care gap.

The CBO numbers are based on national values, and so can't be applied directly, but they show that dramatic costs savings are possible. A December, 2019 Maine Center for Economic Policy analysis of Maine's proposed universal healthcare system shows cost savings for most individuals and employers, including state, local and municipal government. Similarly, a 2015 University of Massachusetts at Amherst analysis of New York's proposed universal healthcare system showed that 98% of New York households would spend less on healthcare under the plan.

HB470 creates a Commission on Universal Healthcare to study how best to implement statewide universal healthcare and develop a plan.

The commission is charged with:

- Determining the funding, operating structure, and health benefit package covering primary care, preventive care, chronic care, acute episodic care, and hospital services;
- Determine how to incorporate Medicare, Medicaid, and the Exchange, state, federal, and municipal employee healthcare, and how to incorporate employee healthcare for employers that choose to participate;
- Develop a plan to contain costs by: providing incentives to residents to avoid preventable health conditions, promote health, and avoid unnecessary emergency room visits; establishing innovative payment mechanisms to health care professionals, such as global payments; and reducing unnecessary administrative expenditures.;
- Analyze whether the health care program should include dental, vision, hearing, and long–term care benefits;
- Apply for Medicare, Medicaid, and ACA waivers; and
- Develop a transition plan and legislation to introduce.

One note about the fiscal note: much work has already been done in this area that the Commission could build on and not have to start from scratch. Although no state has yet implemented a state single-payer universal healthcare plan, several states have done analyses and developed plans that the Commission could use as a starting point. Building on work that's already been done should reduce the cost of the Commission's work. The Kirwan Commission also dealt with a complex topic, and they spent $256,500 on consultants from 2017-2020. It's hard to believe that the Commission on Universal Healthcare would need to spend over ten times as much on consultants as the Kirwan Commission.

I request a favorable report on HB470.

Sources:

A Road Map to 'Single-Payer': How States Can Escape the Clutches of the Private Health Insurance System

Assessing the Costs and Impacts of a State Level Universal Health Care System in Maine

Economic Analysis of the New York Health Act