Memorandum

To: Universal Health Plan Governance Board

From: Jennifer Donovan, Senior Policy Analyst

Date: July 18, 2024

Subject: State Comparison Follow-up

At the June 2024 Universal Health Plan Governance Board meeting, I provided an overview and comparison of the work of three states are making toward universal health care: Vermont, California, and Washington. At that meeting, the board requested information about three additional states that have pursued innovative approaches to health care, information about any other states pursuing universal health care, and information about California's definition of long-term care in its current legislation for a universal health plan. Below I have provided information about health initiatives in Colorado, Massachusetts, and Maryland; general information about other universal health initiatives in the United States; and clarification of the long-term services coverage in California and how they may be integrated into the California plan.

COLORADO

In 2016, Amendment 69 was introduced to Colorado voters. The amendment to the Colorado Constitution would have created ColoradoCare, a no-cost-sharing health plan for all residents of the state, excluding those covered by Medicare or Tricare (but providing supplemental benefits). The measure was rejected by 79 percent of the voters. The program would have been governed by a board of trustees separate from the Colorado state government but with several of its 21 regional appointments made by legislative leadership and the governor. The plan was to be financed by a 6.67 percent employer payroll tax, a 3.33 percent employee payroll tax, and a 10 percent tax on all nonwage income, such as capital gains, self-employment, and Social Security benefits. These tax rates were estimated to be lower than what employers and employees were paying for the premiums of their private health care plans. There was notable disagreement by the Colorado Health Institute (CHI) that this tax rate would amply cover the cost of the program. CHI's analysis of the proposal concluded that costs would likely be covered in the first year, but that there would be a deficit of $7.8 billion by year 10. CHI estimated a 12 percent tax would have eliminated this issue. A state economist argued that CHI's analysis had failed to take cost savings from the new plan into account, but that could not be confirmed.

With the plan being run by a board not connected to state government, drafters provided voting rules specific to the plan, but failed to coordinate the voting process with state laws. ColoradoCare created a separate voting process for residents to weigh in on board proposals. All residents would be eligible, including immigrants without federal citizenship status, but residency was defined differently from Colorado elections law. Normally, the state requires a voter to live in the state for 22 days to establish residency. To vote on ColoradoCare the measure required individuals to live in the state for a year, requiring an additional process for voters to show residency. Additionally, the Colorado Constitution requires voters to have documented citizenship status. These competing voting requirements would have created different groups of voters for the plan and for general elections.

Another state constitutional issue that was not resolved led to the plan losing support from influential public interest groups. The Colorado Constitution prohibits state funds from being

used for abortion. Colorado ballot initiatives may only focus on one issue. The ColoradoCare proposal did not address abortion coverage. However, the abortion advocacy group NARAL said the proposal would take away access for most women in the state through the loss of private insurance. The proponents for the plan argued that Amendment 69 would supersede the 1984 amendment prohibiting the use of state funds for abortion, but the proposal itself was silent on the issue.

In the end, it may have been oppositional messaging, rather than plan design issues that led to the failure of the measure. Together Anthem, Kaiser Permanente, UnitedHealth, Centura, and HealthOne contributed $4 million dollars to the campaign opposing the plan, while public supporters raised $900,000 to promote it. (https://www.vox.com/policy-and-politics/2017/9/14/16296132/colorado-single-payer-ballot-initiative-failure)

Earlier this year, in the 2024 legislative session, House Bill 24-1075 was introduced. The bill required the Colorado School of Public Health to analyze draft model legislation for implementing a single-payer, nonprofit, publicly financed, and privately delivered universal health care payment system for Colorado that would directly compensate providers. The Colorado School of Public Health was required to submit a report detailing its findings to the general assembly by Oct. 1, 2025, (amended to Dec. 31, 2025). The bill also created a statewide health care analysis collaborative consisting of 20 members invited by the executive director of the Department of Health Care Policy and Financing, four members of the general assembly appointed by the president and minority leader of the state Senate and the speaker and minority leader of the state House of Representatives, as well as executive directors of specified state departments, the commissioner of insurance, and the chief executive officer of the Colorado Health Benefit Exchange, or any designees of the executive directors, the commissioner, and the chief executive officer. The analysis collaborative would have been created to advise the Colorado School of Public Health during the analysis. (https://open.pluralpolicy.com/co/bills/2024A/HB24-1075/) The bill passed the Colorado House but was not taken up by the state Senate.

MASSACHUSETTS

Massachusetts passed significant health care reform in 2006, a precursor to the Affordable Care Act (ACA) with many similarities. The program created a health exchange, coverage requirements for individuals, and an employer mandate (repealed in 2013). The program was revised in 2008 and 2010 to comply with ACA.

A single-payer proposal, known as MassCare, has been repeatedly introduced without ever coming to a full vote in the Massachusetts Legislature. In 2023, legislation was again introduced for the MassCare program, but it was not given a hearing by the legislature. The MassCare website says the program will provide "guaranteed access [to all residents], without regard to financial or employment status, ethnicity, race, religion, gender, gender identity, sexual orientation, previous health problems, or geographic location. […] Coverage shall be comprehensive and publicly financed, free of out-of-pocket cost at point-of-care, with no co-insurance, co-payments, deductibles, or any other form of patient cost sharing. (https://masscare.org/legislation/)

The funding proposal for MassCare includes a 10 percent payroll tax (7.5 percent employer, 2.5 percent employee) which would replace employer and employee premiums. A notable departure from other plans is that the first $20,000 of salaries and wages would be exempt for all employers, self-employed individuals, and small business owners. Unearned income (dividends,

interest, capital gains) would also be taxed at 10 percent, excluding the first $20,000. (https://masscare.org/resources-faqs/)

MARYLAND

Maryland is well known for receiving the only Medicare waiver ever granted to a state. In 1977, Maryland was granted a Medicare waiver to set rates and cost controls for hospitals in the state. Referred to as the "all-payer" model, the state set up the Health Services Cost Review Commission (HSCRC) to set rates for specific services for each hospital based on an algorithm. A hospital would be paid for each service under that rate, and revenue depended on volume.

In 2015, Maryland modified the model under its waiver to the "Maryland All-Payer Medicare Model Contract." This new model converted the previous model into a Global Budget Revenue (GBR) model. Hospitals were provided a budget for "regulated" services covered by the waiver and set by the HSCRC. Under this model, hospitals were also held accountable for quality performance measured by outcomes such as readmission rates and hospital-acquired infections. Regulated services were hospital-based inpatient and outpatient services while "unregulated" services, such as physician visits, were still based on a fee-for-service model. The new all-payer model sought to reduce cost per patient and volume of hospital services.

In 2017, the 2015 waiver was amended to include the Care Redesign Program (scheduled to end on Dec. 31, 2018, but retained in the subsequent waiver). This program allowed hospitals to pay incentives to community providers for more collaborative care to improve care quality. Two strategies used by hospitals under this program resulted in improved financial and patient care performance: hospitals began employing more physicians and patient-specific education and coaching.

Maryland and CMS agreed to five-year metrics to evaluate the success of the project. The state met or exceeded all targets. The metrics were:

- Per capita hospital spending growth
- Cumulative hospital Medicare savings
- Reduction in hospital-acquired infections
- Medicare patients' total cost of care
- Medicare 30-day readmissions

Maryland modified its approach again in 2019, evolving the all-payer model into the Total Cost of Care (TCOC) model. The waiver for the new model runs through 2028. Under this new approach, "hospitals are responsible not only for the cost of care for regulated services via the GBR payment methodology, but also for their attributed Medicare patients' cost along the entire continuum of care, including physician services, skilled nursing facilities and non-hospital related healthcare services." (https://www.ascendient.com/higher-thinking/ascendients-guide-to-the-maryland-model-and-the-path-ahead)

The TCOC model seeks to create better coordination of care among hospitals and other care providers. The program allows a Medicare recipient to see any provider under a traditional fee-for-service model, but all Medicare costs under Medicare parts A and B in a hospital's catchment area are attributable to the hospital up to 1 percent of a hospital's Medicare revenue.

In addition to the TCOC, Maryland added an additional program to promote primary care. The Maryland Primary Care Program (MDPCP) is a voluntary program that "pays advanced primary

care providers a per beneficiary per month amount for care management services, as well as incentive payments associated with quality/experience outcomes and reduced hospital/ED utilization." (https://www.ascendient.com/higher-thinking/ascendients-guide-to-the-maryland-model-and-the-path-ahead) Providers have to meet specific requirements to become a participant. To be eligible for the program, providers must use a certified electronic health record and provide services to a minimum of 125 Medicare fee-for-service clients. The program promotes five primary care functions:

- Access to care
- Care management
- Comprehensiveness and coordination
- Patient and caregiver experience
- Planned care and population health

(https://www.hopkinsmedicine.org/-/media/office-of-johns-hopkins-physicians/mdpcpsummary.pdf)

The Maryland waiver programs have succeeded in increasing coordination of care, decreasing volume of utilization of hospital services, and increasing quality of care. Critics, however, point out that the capped revenue based on service leaves out associated costs of care such as facility maintenance, provider education, and data analytics.

Regardless of innovation through its Medicare waiver, the state has also seen the introduction of legislation to enact a single-payer, universal health model in each recent legislative session. None of the recent legislation has been taken up by the Maryland Legislature.

OTHER UNIVERSAL HEALTH CARE INITIATIVES IN THE UNITED STATES

Several states have been working toward universal health care and introducing legislation
A map from a 2019 article on state introduction of single-payer legislation showed that between 2010 and 2019, 19 states had introduced or approved (Vermont) single-payer legislation. (https://www.healthaffairs.org/content/forefront/could-states-do-single-payer-health-care)

Those states were:

Washington
Oregon
California
Michigan
Iowa
Illinois
Ohio
Pennsylvania
Maryland
Delaware
New Jersey
New York
Rhode Island
Massachusetts
New Hampshire
Maine
South Carolina
Florida
Vermont (Passed)

LONG-TERM CARE IN THE HEALTHY CALIFORNIA FOR ALL COMMISSION'S RECOMMENDATIONS

There is not a specific definition of long-term care services in the Healthy California For All Commission's plan. In conversation with advocates of the plan, they assume the plan will seek

to cover what is currently covered under California's version of Medicaid – the Medi-Cal program.

A combination of Medicare and Medi-Cal currently provides most coverage for facility and in-home-based, long-term care services. Services included in Medi-Cal coverage are:

Facility-based services

- Skilled nursing facilities
- Skilled nursing facility special treatment programs
- Subacute care facilities
- Intermediate-care facilities (ICF) for individuals with intellectual disabilities
    - There are four types of ICF facilities
        - ICF/DD (developmentally disabled)
        - ICF/DD-H (habilitative)
        - ICF/DD-N (nursing)
        - DD-CNC (continuous nursing care)

Home- and community-based services (HCBS)

The scope of HCBS varies based on the specific program in which an individual is enrolled. The list of program options is extensive, though not comprehensive. (https://healthlaw.org/wp-content/uploads/2022/12/NHeLP-MediServicesGuide-Chapter-9.pdf)