HB 1144

Department of Legislative Services
Maryland General Assembly
2005 Session

FISCAL AND POLICY NOTE

House Bill 1144 (Delegate Hubbard, *et al.*)
Health and Government Operations

Public-Private Partnership for Health Coverage for All Marylanders

This bill provides universal health care coverage for State residents by changing eligibility requirements in the Medicaid program, the Maryland Children's Health Program (MCHP), the Maryland Pharmacy Discount Program (MPDP), the Maryland Health Insurance Plan (MHIP), and the small group health insurance market.

The bill takes effect July 1, 2005. The provisions that require waivers take effect upon waiver approval.

Fiscal Summary

State Effect: Special fund revenues from the increased cigarette tax are $99.1 million in FY 2006. General fund revenues increase by a significant amount from the bill's payroll tax requirements. The Department of Health and Mental Hygiene (DHMH) expenditures increase by $106.1 million total funds in FY 2006. Department of Labor, Licensing, and Regulation (DLLR) general fund expenditures increase by $25,700 in FY 2006. Future year estimates reflect annualization, increased enrollment, and inflation.

($ in millions)	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010
GF Revenue	-	-	-	-	-
SF Revenue	99.1	88.7	87.2	85.7	84.3
GF Expenditure	51.8	101.7	156.8	180.0	207.3
FF Expenditure	54.4	101.6	154.7	176.4	202.1
Net Effect	($7.1)	($114.5)	($224.3)	($270.6)	($325.2)

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

Local Effect: None.

Small Business Effect: Meaningful. A larger enrolled population in the small group market would spread risk sharing and stabilize health care costs. Increasing the Comprehensive Standard Health Benefit Plan (CSHBP) premium cap from 10% of Maryland's average annual wage to 12% would permit premiums to increase in the small group market.

Analysis

Bill Summary:

Medicaid Expansion

The bill requires DHMH, subject to limitations in the budget, to provide Medicaid coverage for all parents whose annual household income is at or below 100% of the federal poverty level guidelines (FPG) (see **Exhibit 2**), beginning upon waiver approval by the federal Centers for Medicare and Medicaid Services (CMS). Coverage will be extended to 150% FPG on July 1, 2006 and to 200% FPG on July 1, 2007.

Maryland Pharmacy Discount Program Expansion

The bill changes MPDP to permit any individual who lacks drug coverage to enroll.

MCHP Expansion

The bill removes the income limitation in MCHP to permit any child under age 19 to enroll, subject to certain premium requirements. A parent of an eligible child whose family income is above 300% of FPG must pay an actuarially fair premium determined by DHMH. The bill amends eligibility requirements in the small group market to include: (1) an individual under an individual policy; and (2) an individual whose annual family income is above 350% FPG and who does not accept employer-sponsored insurance. The bill also expands the definition of small group employer from one who has 50 employees or fewer to one who has 100 employees or fewer. CSHBP sold in the small group market must retain all of the benefits that existed in the plan as of June 1, 2005.

MHIP Expansion

The bill renames MHIP to MDCare and repeals coverage provisions for medically uninsurable persons. Instead, MDCare provides health insurance coverage to an uninsured individual who: (1) is a resident of the State; (2) whose annual family income

is, in fiscal 2006, below 150% FPG, and in fiscal 2007 and each year thereafter, below 350% FPG; and (3) whose employer offers health insurance coverage that: (a) does not offer comparable benefits to CSHBP; or (b) costs more than 3% of the individual's income for individual coverage or more than 6% of the individual's income for family coverage. In fiscal 2006 only, the MDCare board cannot charge a premium for an uninsured person. The board cannot impose cost sharing requirements on an individual at or below 100% FPG. For an uninsured individual above 100% but below 150% FPG, the board cannot require a deductible and must require a $10 copayment and 10% coinsurance on prescription drugs and services. Beginning in fiscal 2007, the board may modify cost sharing requirements.

MDCare is a quasi-public nonprofit corporation not to be considered an instrumentality of State government. It is not subject to State personnel or procurement law, but it may be funded in the State budget. MDCare must attempt to save money on prescription drug expenditures by implementing a bulk drug purchasing program that includes, in addition MDCare enrollees, Medicaid and MPDP enrollees.

MDCare must develop a state-of-the-art Internet based "electronic-Care Management" (e-CM) system. The e-CM system's functions must include eligibility verification, referral management, automatic claims submission, and direct deposit to provider accounts.

New Entities

The bill establishes the Maryland Quality Institute to: (1) focus on improving the quality of health care for State residents; and (2) develop standardized clinical practice guidelines to be distributed to private and public health plans and provider organizations.

The bill establishes the MDCare Universal Coverage Oversight Commission to study the implementation of universal health coverage. This commission must be staffed by MHCC.

Tobacco Tax Increase

The bill increases the tobacco tax rate for cigarettes from: (1) 50 to 75 cents for each package of 10 or fewer cigarettes; (2) $1.00 to $1.50 for each package of at least 11 and not more than 20 cigarettes; (3) 5 to 7.5 cents for each cigarette in a package of more than 20 cigarettes; and (4) 5 to 7.5 cents for each cigarette in a package of free sample cigarettes. A special fund is created to dedicate certain tobacco tax revenues to increase provider reimbursements in the Medicaid and MHCP programs. After making the required distribution to the refund account and administrative cost account, the

Comptroller must distribute $100 million to the special fund and the remaining balance to the general fund.

Assessment Against Large Employers

The bill creates the Fair Share Health Care Fund. The funds may be used only to support the operations of the Medicaid program. An employer with 10,000 or more employees (see **Exhibit 1**) that does not spend at least 6% of total wages (for a nonprofit employer) or 8% of total wages (for a for-profit employer) on health insurance costs must pay DLLR an amount equal to the difference between what the employer spends on health insurance and the required percentage of total wages paid.

An employer, beginning January 1, 2006, must submit a report to DLLR specifying the amount and the percentage of payroll that was spent on health insurance costs during the previous calendar year. DLLR must annually verify which employers have 10,000 or more employees and ensure that all employers with 10,000 or more employees have made the required report.

Income Taxes on Individuals

For an individual who cannot prove health insurance coverage comparable to CSHBP, and whose federal adjusted gross income is equal to or greater than 350% of FPG, the individual must pay as additional State income tax an amount equal to the hospital share of CSHBP for the taxable year, as established by MHCC.

If an uninsured individual's federal adjusted gross income is less than 350% of the applicable poverty income level and the individual is eligible for MDCare, the individual must be enrolled in MDCare and pay as additional State income tax the applicable MDCare premium. If an individual is eligible for MDCare, Medicaid, or MCHP, the individual must be automatically enrolled and assessed a three-month premium by the Comptroller. Amounts received from these additional personal income taxes or assessed premiums must be distributed to a special fund administered by the Health Services Cost Review Commission to provide reimbursement for uncompensated care.

DHMH Requirements

The bill specifies DHMH will only provide mental health care services to: (1) an uninsured person; (2) a person enrolled in Medicaid; or (3) a person who has health coverage in a public or private program, if the individual is charged at full cost for mental health services.

DHMH must seek approval from the federal CMS for appropriate waivers and amendments to the State Medicaid plan, MCHP, and MPDP that would permit the State to phase-in coverage expansion.

The bill repeals the Alcohol and Drug Abuse Administration's authority to establish facilities and services, including evaluation facilities to determine if an individual is a substance abuser or is dependent on alcohol or drugs.

Current Law: An adult may qualify for Medicaid if the adult is: (1) aged, blind, or disabled; (2) in a family where one parent is absent, disabled, unemployed, or underemployed; or (3) a pregnant woman. Adults must also have very low incomes to qualify for Medicaid (about 46% FPG). MCHP covers children with family incomes up to 300% FPG and pregnant women with incomes up to 250% FPG.

MPDP covers Medicare enrollees without other public or private prescription drug coverage. Enrollees can purchase medically necessary prescription drugs from any pharmacy that participates in the Maryland Medicaid Program at a price that is equivalent to the price reimbursed by Medicaid, including the benefit of any federally mandated manufacturers' rebates.

MHIP is a high-risk pool that covers medically uninsurable individuals in the State.

Background: The Maryland Citizens' Health Initiative established the Maryland Health Care for All Coalition in 1998. The coalition is comprised of 2,000 diverse organizations, including religious, health, community, labor, and business groups from across the State. The coalition seeks to provide all State citizens with access to comprehensive, affordable health care. In September 2001, the coalition released a draft plan for achieving "health care for all" in Maryland. Since then it has revised the draft based on hundreds of comments sent by coalition members and the general public. In October 2003, the coalition released its final plan. This bill reflects many of the recommendations made by the coalition.

State Revenues:

Cigarette Tax: The bill requires that at least $100 million in cigarette tax revenue be deposited into a special fund used solely for subsidizing health care provider reimbursements. Increasing the tobacco tax from $1 per cigarette pack to $1.50 per pack would increase revenues by about $99.1 million. This estimate reflects the following facts and assumptions:

- a 50-cent excise tax on cigarettes generates $89.5 million additional revenue;

- a 50-cent floor tax on existing cigarette inventory generates $8.9 million; and

- the excise tax increases sales tax on cigarettes by $720,500.

Future year estimates reflect no floor tax, a 2% trend decline due to fewer cigarettes sold, and would not cover the $100 million annual deposit required by the bill.

Employer Assessment: To the extent large employers do not spend at least 6% or 8% on health insurance costs as required, Fair Share Health Care Fund special fund revenues could increase from employers' paying the difference between the required and actual amounts spent on health insurance. Since the amount an employer may be required to pay for health insurance is significant (see Exhibit 1), it may be more efficient for an employer to pay the $250,000 civil money penalty annually rather than pay the required assessment. It is assumed any penalty would be paid to the fund as well. There are insufficient data to reliably estimate any revenue increase.

Income Tax: The bill requires an uninsured individual who earns more than 350% FPG to pay as additional State income tax an amount equal to the hospital share under CSHBP. Maryland's average annual wage in 2003 was $40,714, significantly higher than the 2005 FPG rate of 350%, which is $33,495. It is assumed that most people over 350% FPG have health insurance, and if not, would purchase it to avoid the tax. Any tax revenue generated under this provision is assumed to be minimal.

State Expenditures:

Medicaid: Medicaid expenditures could increase by an estimated $106,129,307 in fiscal 2006, which assumes waiver approvals and that enrollment begins January 1, 2006. This estimate reflects covering 35,646 individuals in fiscal 2005 under Medicaid and MCHP, an additional 20,567 in MPDP, and an enrollment reduction in the Maryland Pharmacy Assistance Program (MPAP) and the Maryland Primary Care Program (MPCP). The estimate reflects the following facts and assumptions:

- Medicaid expansion covers 16,132 parents at $4,266 per enrollee and 13,289 children at $1,836 per enrollee in fiscal 2006;
- MCHP premium expansion covers 6,225 new kids in fiscal 2006 at $1,270 per enrollee;
- MCHP expenditures increase due to the discontinuation of premium contributions in MCHP for enrollees who earn between 185% and 200% FPG;
- MPDP program covers 20,567 new individuals in fiscal 2006 at $472 per enrollee;

- Medicaid enrollees do not have cost sharing;
- MCHP enrollees with incomes over 300% FPG pay premiums ranging from $650 to $1,168 annually, depending on income;
- specialty mental health coverage for approximately 15% of enrollees, or 4,906 new enrollees, costs $4,852 per adult and $5,339 per child;
- MPCP general fund expenditures decrease by at least $7.2 million from reduced enrollment;
- MPAP expenditures decrease by $23,934,079 from reduced enrollment; and
- administrative costs increase by $7,572,129 in fiscal 2006 for 35 new positions to process new enrollees, programming and maintenance changes to the Medicaid Management Information Systems database, enrollment broker costs, and ongoing operating expenses.

Future year estimates reflect annualization, additional enrollment as the income caps increase, 5.8% medical inflation in the Medicaid program, and 12% prescription drug inflation in MPDP and MPAP.

It is important to note that the bill specifically excludes Medicaid-eligible or MCHP-eligible individuals from enrolling in MDCare but it also requires Medicaid to enroll newly eligible Medicaid parents in MDCare. This estimate assumes that Medicaid does not enroll any individuals in MDCare since MDCare coverage may not be as comprehensive as Medicaid benefits, and could be more expensive.

Further, the bill specifies the tobacco tax revenues must be used to increase provider fees. This provision may preclude the use of tobacco tax revenues for Medicaid administrative costs associated with the expansion.

To the extent Medicaid enrollees are working for large employers who now begin to offer health insurance, Medicaid expenditures could decrease.

Maryland Health Care Commission: MHCC special fund expenditures could increase by an estimated $394,765 in fiscal 2006, which accounts for a 90-day start-up delay. This estimate reflects the cost of contracting with a consultant to assist with data collection and hiring three policy analysts to staff the MDCare Oversight Committee. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits	$173,840
Consultant Contract for Data Collection	200,000
Operating Expenses	20,925
Total FY 2006 State Expenditures	**$394,765**

Future year expenditures reflect: (1) full salaries with 4.6% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

DLLR Collection of Large Employer Health Benefits Coverage Reports: General fund expenditures for DLLR could increase by as much as $25,749 in fiscal 2006 to manage large employer reports on health insurance coverage. This estimate reflects the cost of hiring one part-time accountant to collect and verify employer reports and remit any funds to DHMH. Future year expenditures reflect: (1) full salaries with 4.6% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

Other Expenditures: MDCare must provide health insurance coverage to an uninsured individual with specified income. In addition, MDCare must develop a state-of-the-art Internet based e-CM system. There are insufficient data to reliably estimate premium revenues or health care and administrative expenditures under MDCare.

Additional Comments: According to DLLR, there were three entities at the end of fiscal 2004 that employed more than 10,000 employees, including Giant Food, Wal-Mart, and Johns Hopkins University (see **Exhibit 1**).

Exhibit 1
Employers with 10,000 or More Employees

Employer	Employees	Total Wages	Amount Required to be Spent on Health Insurance
Giant Food	18,902	$536,050,814	$42,884,065
John Hopkins University	14,729	$858,997,834	$51,539,870
Wal-Mart	14,301	$270,333,508	$21,626,681

Exhibit 2
2005 Federal Poverty Guidelines for One Person*

100% FPG	$ 9,570
150% FPG	$14,355
200% FPG	$19,140
250% FPG	$23,925
300% FPG	$28,710
350% FPG	$33,495
400% FPG	$38,280

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Additional Information

Prior Introductions: A substantially similar bill, HB 1008, was introduced in 2004. It was not reported by the Health and Government Operations Committee.

Cross File: None.

Information Source(s): Department of Health and Mental Hygiene (Family Health Administration, Medicaid, Community Health Administration, Mental Hygiene Administration); Maryland Insurance Administration; Department of Budget and Management (Employee Benefits Division); *Estimated Maryland Revenues, Fiscal years ending June 30, 2004 and June 30, 2005*, Bureau of Revenue Estimates; Comptroller's Office; Department of Legislative Services

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Analysis by: Susan D. John

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