HB 462

Department of Legislative Services

Maryland General Assembly
2007 Session

FISCAL AND POLICY NOTE

House Bill 462 (Delegate Nathan-Pulliam, *et al.*)
Health and Government Operations and Appropriations

Office of Minority Health and Health Disparities - Grant Program and Funding

This bill creates a Health Disparities Grant Program within the Office of Minority Health and Health Disparities and requires $2.6 million annually from the Cigarette Restitution Fund (CRF) to fund the office.

The bill takes effect July 1, 2007.

Fiscal Summary

State Effect: Special fund expenditures would increase by $2.6 million annually beginning in FY 2008 to fund the office, assuming a sufficient CRF fund balance. No effect on revenues.

($ in millions)	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Revenues	$0	$0	$0	$0	$0
SF Expenditure	2.6	2.6	2.6	2.6	2.6
Net Effect	($2.6)	($2.6)	($2.6)	($2.6)	($2.6)

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

Local Effect: None.

Small Business Effect: Meaningful for small business community-based organizations that receive grants.

Analysis

Bill Summary: The stated purpose of the program is to provide grants to (1) community-based organizations and historically black colleges and universities to conduct special research, demonstration, and evaluation projects for targeted at-risk racial and ethnic minority populations; and (2) community-based organizations and other health care providers that demonstrate the capacity to reduce health disparities and that use interventions listed in the office's plan to reduce health care disparities.

The office must establish grant criteria; establish a grant evaluation system that includes data collection to evaluate the grantee's programs; and require grantees to comply with the evaluation system and report quarterly on their compliance. The office must consult with local minority groups when reviewing and approving grant applications.

The bill repeals the office's existing requirement to obtain funding and provide grants for community-based organizations and historically black colleges to conduct projects addressing at-risk racial and ethnic minority populations and develop the criteria for awarding grants.

The bill provides that the office serves as the designated State agency for receipt of *general* and *special* funds, in addition to federal funds, specifically designated for minority health and health disparity programs. The office is also authorized to distribute grants from available general funds, not just special and federal funds to community-based health groups.

Funding for the office must come from the CRF. For each fiscal year for which appropriations are made, at least $2.6 million must be used to fund the office. The appropriation may not supplant any other CRF-required appropriation or CRF appropriation made prior to fiscal 2009.

The bill also changes the CRF funding priorities by adding the office as the third priority (for which, along with funding for the Tobacco Use and Cessation Program and the Cancer Prevention, Education, Screening, and Treatment Program, at least 50% of the appropriations must be made) and by repealing the requirement that CRF funds may be used for the Maryland Health Care Foundation's purposes.

Current Law: Chapter 443 of 2004 created the Office of Minority Health and Health Disparities within the Department of Health and Mental Hygiene (DHMH) to advocate for the improvement of minority health care and help the Secretary of Health and Mental Hygiene identify, coordinate, and establish priorities for programs, services, and resources that the State should provide for minority health and health disparities issues.

The office, among other duties, also must obtain funding and, contingent upon the funding, provide grants to community-based organizations and historically black colleges and universities to conduct special research, demonstration, and evaluation projects for targeted at-risk racial and ethnic minority populations and support ongoing community-based programs designed to reduce or eliminate racial and ethnic health disparities and develop the criteria for awarding the grants.

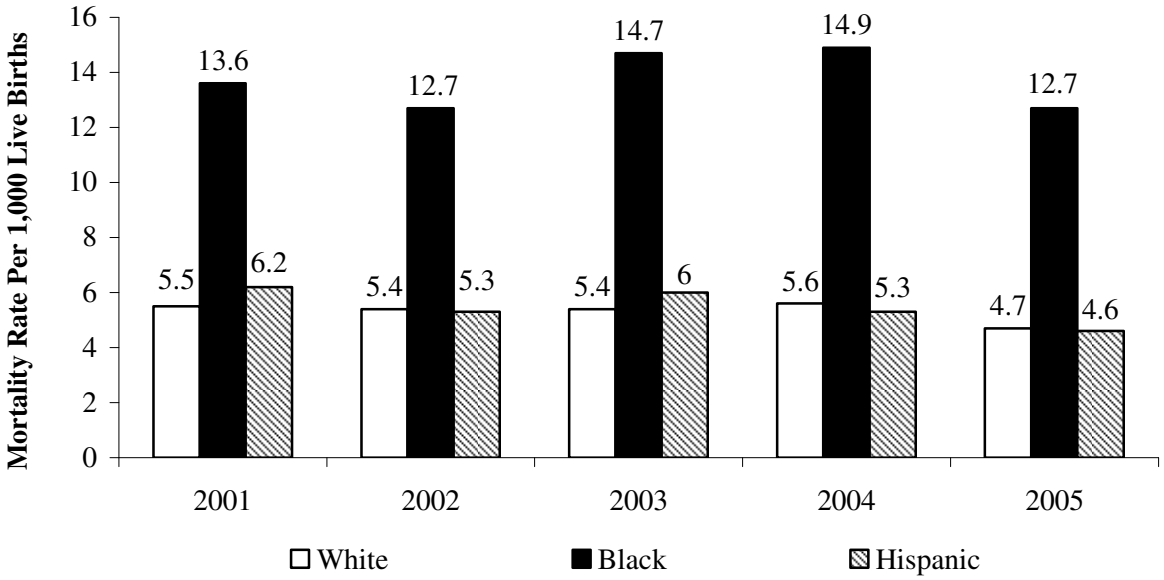
DHMH must submit an annual report on the office to the Governor and the General Assembly on the projects and services developed and funded by the office and the health care problems the grants are intended to ameliorate; and any recommendations.

CRF is a special, nonlapsing fund supported by revenue from a settlement with the five major tobacco companies. Under the Master Settlement Agreement (MSA) participating manufacturers agreed to compensate the states for smoking-related medical costs and conform to certain marketing restrictions. CRF funds must be used to fund: the Tobacco Use Prevention and Cessation Program; the Cancer Prevention, Education, Screening, and Treatment Program; and other programs that serve health-related purposes as specified in statute. For each fiscal year for which CRF appropriations are made, at least 50% of the appropriations must be for these purposes.

Background: Documented health disparities exist in the United States and Maryland among racial and ethnic minority populations. In response to the Maryland General Assembly's continuing interest in health disparities, the Department of Legislative Services (DLS) issued a report in January 2007 examining the extent of health disparities and emerging health disparities issues.

One of the health disparities DLS examined was infant mortality by race and ethnicity. Infant mortality rates statewide were three times higher in 2005 for black infants than white and Hispanic infants. As shown in **Exhibit 1**, the infant mortality rate was 12.7 per thousand live births for blacks compared to 4.7 for whites and 4.6 for Hispanics. Over the five-year period, the infant mortality rate for blacks has fluctuated but remained much higher than the rates for whites and Hispanics. The United Health Foundation ranked Maryland 44 in the country on infant mortality. This is an improvement over the 2005 ranking in which Maryland was ranked 46.

Exhibit 1
Infant Mortality Rates in Maryland by Race and Hispanic Origin
2001-2005



Note: Data for Hispanics are included in the data for each race. The Hispanic infant mortality rate includes all deaths to Hispanics of any race.

Source: Maryland Vital Statistics Preliminary Report, 2005

Another health disparity DLS examined was the HIV and AIDS prevalence rates (the number of individuals diagnosed as living with the HIV and AIDS) by race and ethnicity. As demonstrated in **Appendix 1 (Exhibit 4.9 from Health Disparities Report)**, HIV and AIDS prevalence rates in Maryland from 2000 through 2004 showed a significant disparity between blacks and every other racial and ethnic group. The rate of blacks living with HIV and AIDS has progressively increased from 2000 to 2004. In 2004, the prevalence rate for blacks was 13 times greater than for whites.

Significant Reductions in CRF Funding Possible

Legal actions by manufacturers participating in the MSA threaten to reduce the amount of tobacco settlement revenues available to the states. These manufacturers contend that manufacturers not participating in the agreement have increased their share of the market by exploiting legal loopholes to reduce their escrow payments to the states, giving those manufacturers a competitive advantage in the pricing of their products.

In March 2006, an arbitrator ruled that the MSA was a significant factor contributing to the participating manufacturers' 2003 loss of market share. The ruling entitled the tobacco manufacturers to reduce their 2006 Master Settlement payment by approximately $1.1 billion, or 18%, of which Maryland's share is approximately $26 million. The agreement provides that the adjustment will apply to all states unless a state has enacted and is diligently enforcing its qualifying statute that is intended to level the playing field with respect to price between participating and nonparticipating tobacco manufacturers. Maryland enacted its qualifying statute in 1999 and amended it in 2001 and 2004. If one state wins diligent enforcement, that state's share of the adjustment will be deducted from those states that are found not to have diligently enforced the statute. As a result, Maryland's share of the 2003 adjustment could exceed $26 million.

Pending resolution of the diligent enforcement proceedings, the participating manufacturers placed $781.8 into a disputed payments account, reducing Maryland's 2006 payment by $17.7 million. The initial adjustment was not fully deducted because several participating manufacturers elected to make their full 2006 payments. If the tobacco manufacturers win the diligent enforcement proceedings, the manufacturers who elected to make the full 2006 payment would have the option to offset future payments.

Once the legal proceedings are concluded and if Maryland is found to have diligently enforced its qualifying statute, the $17.7 million in the disputed payments account will be released to the State. If it is determined that Maryland has not diligently enforced its qualifying statute, the State's CRF fund revenues could be reduced by between $26 million and the State's full 2006 Master Settlement payment, approximately $158.2 million. The actual amount would depend on how many other states are found not to have diligently enforced their qualifying statute. The fiscal 2007 State budget restricted $26 million in the Medicaid appropriation, pending conclusion of the proceedings.

In April 2006, the participating manufacturers again gave notice to the State Attorneys General that they were pursing an adjustment with respect to a loss of market share in sales year 2004. The amount of the 2004 adjustment will be about the same as the 2003 adjustment, approximately $1.1 billion, of which Maryland's share is approximately $26.5 million. The reduction will be applied to the fiscal 2007 payment due April 15, 2007. Additionally, the participating manufacturers have indicated that they intend to initiate a significant factor determination for sales year 2005.

State Fiscal Effect: Special fund expenditures could increase by $2.6 million annually beginning in fiscal 2008 for grants to community-based organizations, historically black colleges and universities, and health care providers. The money would also be used to

hire a program administrator and administrative officer to administer the program and pay for a $18,750 contract ($25,000 annualized) with a vendor to conduct regional grantee trainings on effective ways to reduce health disparities.

Health Disparities Grants	$2,478,802
Salaries and Fringe Benefits	85,712
Contract for Regional Grantee Trainings	18,750
Other Operating Expenses and Travel Costs	16,736
Total FY 2008 State Expenditures	**$2,600,000**
Positions	2

To the extent that MSA payments to Maryland's CRF fund vary, the amount available to award grants and loans and pay for staffing and operational costs also will vary. If the CRF fund balance is eliminated as a result of the potential significant reductions in MSA payments, little if any funding would be available to implement this bill.

Fiscal Year	Balance
2007	$17.0 million
2008	3.7 million
2009	5.2 million
2010	3.6 million

Source: Department of Budget and Management

Additional Information

Prior Introductions: A similar bill, HB 568 of 2006, had a joint hearing before the House Health and Government Operations Committee and the House Appropriations Committee, but no further action was taken. Its cross file, SB 937, had a joint hearing before the Senate Education, Health, and Environmental Affairs Committee and the Senate Budget and Taxation Committee, but no further action was taken.

Cross File: None.

Information Source(s): Morgan State University; Department of Health and Mental Hygiene; University of Maryland Medical System; *Health Disparities*, January 2007; Department of Legislative Services

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bfl/jr

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