SB 715

Department of Legislative Services

Maryland General Assembly
2004 Session

FISCAL AND POLICY NOTE

Senate Bill 715 (Senators Hollinger and Middleton)
Finance

Access to Health Care and Community Health Care Safety Net Act of 2004

This bill establishes the Maryland Community Health Resources Commission (CHRC) to increase access to health care for lower-income individuals and provide resources to community health centers around the State. In addition, Medicaid must provide primary and specialty health care services for adults whose annual income is at or below 100% of the federal poverty level guidelines (FPG).

Fiscal Summary

State Effect: General fund revenues decrease by $840,000 in FY 2005 from the corporate income tax exemption applied to HMOs and Medicaid managed care organizations (MCOs) that are now subject to the premium tax. Special fund revenues are $46.95 million in FY 2005 reflecting $47.21 million new premium tax revenues dedicated to the CHRC fund and a $265,000 revenue reduction in the Transportation Trust Fund (TTF). This figure does not reflect potential significant special fund revenues from the payroll tax or any surplus in the Maryland Health Insurance Plan (MHIP). Department of Labor, Licensing, and Regulation (DLLR) general fund expenditures increase by $30,000 in FY 2005. Medicaid expenditures increase by $29.73 million (50% federal funds, 50% special funds) in FY 2005. CHRC special fund expenditures are $1.43 million for administrative costs in FY 2005. This figure does not reflect potential significant special fund expenditures to provide grants to community health resources (CHRs). State Insurance Trust Fund special fund revenues and expenditures could each increase in FY 2005. Future year estimates reflect annualization and inflation.

($ in millions)	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
GF Revenue	($.84)	($1.85)	($2.05)	($2.26)	($2.50)
SF Revenue	46.95	108.04	90.69	101.59	113.90
GF Expenditure	.03	.02	.02	.03	.03
SF Expenditure	16.30	32.02	36.66	41.98	48.10
FF Expenditure	14.86	30.89	35.48	40.75	46.81
Bond Exp.	2.40	3.00	3.00	3.00	3.00
Net Effect	$12.51	$40.24	$13.48	$13.57	$13.46

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

Local Effect: Corporate income tax revenues that are remanded to local jurisdictions for local highway purposes could decrease by a minimal amount.

Small Business Effect: Minimal.

Analysis

Bill Summary: Medicaid must provide adults with income under 100% FPG (see **Exhibit 1**) primary and specialty health care services from licensed or certified health care providers that are provided by a CHR. A CHR is a nonprofit health care center or program that offers primary health care services to an individual on a sliding scale fee basis without regard to an individual's ability to pay. This program takes effect on the date Medicaid receives waiver approval from the federal Centers of Medicare and Medicaid Services (CMS).

CHRC must identify uninsured individuals who earn less than 300% FPG and assign them to a CHR where they may receive primary care services. Individuals who earn less than 100% FPG may obtain services at no charge. CHRC must develop a sliding scale copayment for individuals who earn 100% to 300% FPG for services rendered at a CHR.

CHRC must facilitate access to CHRs by doing such things as identifying and seeking federal and State funding for CHR expansion, administering operating and capital grant funding for CHR expansion, and developing and implementing programs to provide incentives to specialist providers to serve individuals referred from CHRs.

The Motor Vehicle Administration (MVA) must collect information on an individual's income and health insurance coverage when an individual registers a motor vehicle or applies for or renews a driver's license or identification card and provide the information to CHRC. An individual is not required to provide information to the MVA. CHRC must use the information to refer uninsured individuals with income under 300% FPG to CHRs. CHRC must refer persons with income under 100% FPG beginning October 1,

2005, under 200% FPG beginning October 1, 2006, and under 300% beginning October 1, 2007. CHRC must establish a toll-free hotline for callers to receive information and enrollment assistance.

Premium tax exemption repeal: HMOs and Medicaid MCOs are required to pay the 2% premium tax that other for-profit carriers must pay. Funds must be distributed to the CHRC fund. The tax takes effect October 1, 2004.

Payroll Tax: All nongovernmental employers that employ more than 10,000 employees must pay an annual payroll tax to DLLR. For nonprofit employers the tax rate is 6% of the total wages paid to employees in the State during each calendar year and for for-profit employers the tax rate is 8%. An employer may claim a credit against the payroll tax, up to the amount of the tax imposed, in an amount equal to the employer's health insurance expenditures. An employer may not deduct the payroll tax from an employee's wages. The payroll tax revenues must be deposited in the CHRC fund.

CHRC Fund: The bill establishes a CHRC fund that consists of HMO and Medicaid MCO premium taxes, new payroll taxes, any State savings in the various prescription drug programs realized because of the new Medicare prescription drug benefit, and any excess funds in the MHIP fund. The fund is used to cover CHRC administrative costs, provide grants to qualifying CHRs, provide funds to Medicaid to cover enrollee costs for those with incomes between 45% and 100% FPG, and provide stipends to specialists in CHRs.

Federally Qualified Health Centers (FQHCs) Grant Program: On the recommendation of the Secretary of Health and Mental Hygiene, the Board of Public Works (BPW) may make grants to counties, municipal corporations, and nonprofit organizations for the conversion of public buildings to FQHCs; the acquisition of existing buildings for use as FQHCs; the renovation of FQHCs; the purchase of capital equipment for FQHCs; or the planning, design, and construction of FQHCs. The bill establishes requirements and limitations on the use of FQHC grant funds. The program takes effect October 1, 2004.

Sovereign Immunity for CHR Health Care Providers: A health care provider who contracts with CHRC or with a CHR is considered a State employee and therefore immune from liability for tortious acts or omissions unless made with malice or gross negligence.

Small Employer Health Insurance Program: This program must provide a health insurance option to an employer with 50 or fewer employees that permits the employer to contract with a CHR to provide primary health care to employees. The program takes effect upon waiver approval by CMS.

Waivers: The Department of Health and Mental Hygiene (DHMH) must seek approval from CMS for appropriate waivers and amendments to the State Medicaid plan that would permit the State to phase in the bill's coverage expansions.

Other Provisions: The bill establishes a council on hospital and community health resources relations within CHRC. The council must make recommendations to CHRC on proposals to encourage hospitals and CHRs to partner to increase health care access. The council must report its findings and recommendations to the Governor and the General Assembly by October 1, 2006.

The bill establishes an Advisory Council on School-based Community Health Center Expansion to study and make recommendations related to the expansion of school-based community health centers that would provide primary and specialty care to community members. The council must report its findings and recommendations to the Governor and the General Assembly by December 1, 2005.

A health insurer, nonprofit health service plan, HMO, or dental plan organization (carrier) must pay a CHR at a rate that is equal to the rate paid by Medicaid, which is $138 per visit.

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.

The Maryland Primary Care Program (MPCP) covers individuals enrolled in the Maryland Pharmacy Assistance Program (MPAP) who earn up to 116% FPG. The MPCP provides primary care health services. MPCP has about 8,000 enrollees.

MHIP: MHIP is a high-risk health insurance pool that provides comprehensive health coverage to medically-uninsurable individuals. There are approximately 7,100 enrollees.

Maryland Tort Claims Act: State personnel are immune from suit and from liability in tort for a tortious act or omission that is within the scope of State personnel public duties and is made without malice or gross negligence.

The State Insurance Program provides and administers purchased insurance and self-insurance for the State to protect against loss, damage, and liability that the State may incur. There is a State Insurance Trust Fund used to cover State-incurred losses, including losses resulting from a settlement or judgment against the State. The fund consists of general and special fund appropriations in the State budget and premiums

assessed against units of State government. The Treasurer administers the program and its fund. The fund's estimated balance for fiscal 2005 is about $1.5 million, which is much lower than the recommended actuary balance of $26.2 million.

Background: FQHCs are private, not-for-profit health care centers that provide comprehensive primary and preventive care to medically underserved and uninsured people. Some FQHCs provide limited specialty care. They are not permitted to refuse care based on ability to pay. FQHCs provide free health care services to individuals earning less than 100% FPG. For persons with incomes between 100% and 200% FPG, FQHCs impose a sliding scale copayment.

Federal legislation recently created "Medicare Part D," an optional prescription drug program for Medicare enrollees. The first phase of the new program will be implemented in June 2004 providing pharmacy discount cards, and in some cases, subsidizing drug costs for eligible Medicare enrollees. The new federal program will have significant fiscal implications for State drug programs; expected general fund savings are about $27 million in fiscal 2006.

State Revenues: CHRC special fund revenues would be at least $47 million in fiscal 2005, which reflects the bill's October 1, 2004 effective date for most programs. The CHRC fund is funded by the HMO/MCO premium tax, the payroll tax, savings in State prescription drug programs due to the implementation of a Medicare prescription drug benefit, and any surplus funds in MHIP.

HMO/MCO Premium Tax: Premium tax revenues from HMOs and MCOs subject to the 2% premium tax could be as much as $47 million in fiscal 2005. Subjecting HMOs and MCOs to the premium tax would reduce the amount of corporate income taxes they must pay. It is estimated corporate tax revenue could decrease by as much as $1.1 million in fiscal 2005, reducing revenues to both the general fund and the TTF. Premium tax revenues would be deposited in the CHRC fund.

Payroll Tax: The bill requires a nongovernmental employer with 10,000 or more employees must pay 6% payroll tax if they are nonprofit, and an 8% payroll tax if they are for-profit. Employers may claim a credit in an amount equal to what the employer spent on health insurance for its employees.

According to the Bureau of Economic Analysis, in 2003, nongovernment compensation in Maryland totaled $101.4 billion. Accordingly, the payroll tax could generate between $6 and $8.1 billion in additional revenue from all nongovernment employers, not just those with over 10,000 employees. This revenue would be offset by employers' spending on health insurance for their employees, which averages 6.32% of total compensation, or $5.95 billion. Net revenues would be $50,000 to $1.7 billion. Various sources indicate

there are four nongovernmental businesses in Maryland that employ more than 10,000, including Johns Hopkins University, Giant Food, and Johns Hopkins Health System. One source indicates WalMart is the fourth largest employer while another source states it is Verizon. There are insufficient data to reliably estimate the total payrolls for each of these entities and subsequently how much payroll tax they would pay. Revenues would be deposited in the CHRC fund.

Savings from Prescription Drug Programs: Special fund revenues could increase by $27 million from savings in the State prescription drug programs in fiscal 2006 only. It is assumed that these State programs would either be discontinued after the implementation of the Medicare prescription drug benefit, or significantly restructured to address only the remaining gaps in prescription drug coverage. Savings would be deposited in the CHRC fund.

MHIP Surplus: The amount of surplus funds in the MHIP fund, if any, is unavailable at this time. Any surplus would be deposited in the CHRC fund.

Future year fund estimates reflect inflation.

State Insurance Trust Fund: Health care providers that contract with CHRC or CHRs are considered State personnel for the purpose of extending the State's sovereign immunity to them. It is unclear whether this provision would require or even permit health care providers to pay premiums into the State Insurance Trust Fund. Special fund revenues could increase from any premiums collected from participating providers, beginning in fiscal 2005. Future year estimates depend on the number of providers that are required or choose to participate and the extent of any claims made against the fund.

Medicaid: Since the bill permits CHRC to fund the Medicaid expansion, it is assumed that CHRC will transfer an amount to cover Medicaid's general fund expenditures related to the expansion. In fiscal 2005, it is assumed Medicaid would receive $14.86 million special fund revenues from CHRC.

State Expenditures:

Medicaid: Medicaid expenditures could increase by at least $29,729,468 (50% federal funds, 50% special funds) in fiscal 2005, which assumes CMS will approve the waiver application and enrollment for this program will begin January 1, 2005.

The information and assumptions used in calculating the estimate are stated below:

- there are 100,000 people under 100% FPG who are uninsured;
- of these, 36,675 will enroll;

- Medicaid capitation rates for primary and specialty care services at CHRs is $1,400 annually;
- Medicaid hires 16 health policy analysts, data processing programmer analysts, and income maintenance specialists to conduct claims processing, provider relations, enrollment, hotline management, computer programming, waiver development, and eligibility determinations; and
- there is a one-time $2 million cost to program the mainframe to accept a new coverage group.

Future year estimates reflect annualization and 6.5% medical inflation in the Medicaid program.

Specialty Mental Health Services: It is important to note that the Medicaid expansion to cover individuals up to 100% FPG may make these new enrollees eligible for specialty mental health services provided through DHMH's Mental Hygiene Administration. Generally, 20% of Medicaid enrollees obtain specialty mental health services. If new enrollees are eligible for specialty mental health services, Medicaid expenditures could increase by an *additional* $33 million (50% federal funds, 50% special funds) in fiscal 2005.

Other Medicaid Expenditures: It is assumed the Small Employer Health Insurance Program would have minimal impact on the Medicaid program. Only about 3,000, or 1%, employees in private firms are covered through Medicaid. If Medicaid expands to adults up to 100% FPG, additional employees may be eligible. Any savings from employer contributions to coverage are assumed to be minimal.

Enrolling additional adults in Medicaid could result in more children being covered by Medicaid. There are insufficient data at this time to reliably estimate any enrollment and subsequent expenditure increase.

CHRC: CHRC special fund expenditures would be an estimated $1,433,549 million in fiscal 2005. This estimate reflects the cost of 15 new positions, including an executive director, deputy director, three program managers, two grants managers, two specialist incentive analysts, four enrollment clerks, and two computer network specialists to perform the duties required by the bill. It provides $500,000 to hire consultants to provide a toll-free hotline, establish a uniform data set to be used as the criteria for providing funding to CHRs, and develop other data management systems. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits	$825,249

Consultant Contract	500,000
Other Operating Expenses	108,300
Total FY 2005 State Expenditures	**$1,433,549**

In addition, CHRC will provide grants to CHRs in order to increase access to primary care services; however, the nature and amount of any grants cannot be reliably estimated at this time.

Future year expenditures reflect: (1) full salaries with 4.6% annual increases and 3% employee turnover; (2) $250,000 ongoing annual consultant fees; and (3) 1% annual increases in ongoing operating expenses.

DLLR Administration of Payroll Tax: General fund expenditures for DLLR could increase by as much as $30,515 in fiscal 2005 to set up a new payroll tax collection unit. DLLR currently collects payroll taxes for unemployment insurance; however, it is a 100% federally-funded program and cannot be used for any purpose other than unemployment insurance. This estimate reflects the cost of hiring two part-time contractual clerks to handle collection, billing, enforcement, and wage database access. It also includes a one-time $10,000 expenditure to make computer database changes. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses. Future year expenditures reflect: (1) full salaries with 4.6% annual increases and 6.8% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

MVA: It is assumed the MVA could collect data voluntarily submitted by individuals who renew registrations, driver's licenses, or identification cards with existing budgeted resources. *The MVA did not respond to a request for information about this bill.*

FQHCs Grant Program: The Governor's proposed fiscal 2005 capital budget includes $2.4 million in general obligation bonds to provide funding for five FQHC projects that will provide or expand medical space for an additional 14,500 patients. Future year bonds are $3 million annually as projected in the estimate included in the proposed capital budget.

State Insurance Trust Fund: Health care providers that contract with CHRC or CHRs are considered State personnel for the purpose of extending the State's sovereign immunity to them. It is unclear whether this provision would require or even permit health care providers to pay premiums into the State Insurance Trust Fund. If participation in the trust fund is required or permitted, trust fund expenditures could increase by a significant amount, beginning in fiscal 2005, depending on the nature and frequency of any claims made by participating CHR health care providers. The Treasurer is authorized to set and

charge premiums for participation in the State Insurance Program, but there are not enough data to reliably estimate: (1) the number of eligible CHR providers that may participate in the program; (2) the premium rate the Treasurer would assess against participating providers; or (3) the number of claims, if any, made by participating providers.

Additional Comments:

Exhibit 1
2004 Federal Poverty Guidelines for One Person*

100% FPG	$ 9,310
150% FPG	$13,965
200% FPG	$18,620
250% FPG	$23,253
300% FPG	$27,930
350% FPG	$32,585
400% FPG	$37,240

**Federal Register, Vol. 69, No. 30, February 13, 2004, pp. 7336-7338.*

Additional Information

Prior Introductions: None.

Cross File: HB 1271 (Delegate Hurson, *et al.*) – Health and Government Operations is identified as a cross file, but is different.

Information Source(s): Department of Health and Mental Hygiene (Medicaid, Community Health Administration, Family Health Administration, AIDS Administration, Developmental Disabilities Administration, Maryland Health Care Commission); Department of Labor, Licensing, and Regulation; Comptroller of the Treasury; Maryland Insurance Administration; Department of Legislative Services

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