SB 737

Department of Legislative Services
Maryland General Assembly
2004 Session

FISCAL AND POLICY NOTE

Senate Bill 737 (Senator McFadden, *et al.*)
Finance

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.

Fiscal Summary

State Effect: Medicaid expenditures increase by $98.21 million ($53.23 million federal funds, $44.99 general funds) in FY 2005. Medicaid special fund revenues increase by $1.10 million from new MCHP premiums in FY 2005. Maryland Health Care Commission (MHCC) special fund expenditures increase by $335,000 in FY 2005. Department of Labor, Licensing, and Regulation (DLLR) general fund expenditures increase by $30,500 in FY 2005. Special fund revenues from the increased cigarette tax are $107.8 million in FY 2005. General fund revenues increase by a significant amount from the bill's payroll tax requirements. Future year estimates reflect annualization, increased enrollment, and inflation.

($ in millions)	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
GF Revenue	-	-	-	-	-
SF Revenue	108.90	97.70	97.33	96.59	95.91
GF Expenditure	45.02	172.41	290.86	327.55	383.82
SF Expenditure	.34	.38	.39	.40	.42
FF Expenditure	53.23	183.14	303.03	340.97	398.65
Net Effect	$10.32	($258.23)	($496.95)	($572.33)	($686.97)

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: The bill requires the Department of Health and Mental Hygiene (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 1**), beginning upon waiver approval by the federal Centers for Medicare and Medicaid Services (CMS). Coverage will be extended to 150% FPG on July 1, 2005 and to 200% FPG on July 1, 2006.

The bill changes MPDP to permit any individual who lacks drug coverage to enroll. 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 400% 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, 2003.

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 2005, below 150% FPG, and in fiscal 2006 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 2005, 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 2006, the board may impose higher 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 Maryland Pharmacy Discount Program (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.

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.

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.

The bill also requires all employers other than the federal government, the State, another state, or a political subdivision of the State or of another state, to pay an annual payroll tax: (1) equal to 4.5% of the total wages paid to employees in the State during each calendar year, if the employer has fewer than 10,000 employees; (2) equal to 6% of the total wages if the employer has more than 10,000 employees and is a nonprofit organization; or (3) equal to 8% of the total wages if the employer has more than 10,000 employees and is a for-profit entity. An employer may claim a credit against the payroll tax, up to the amount of the tax imposed, in an amount equal to the amount of the employer's expenditures during the calendar year to provide health insurance to employees in the State if the employer's health insurance costs are deductible under federal tax law. An employer may not deduct the payroll tax from an employee's wages.

MDCare may increase the payroll tax percentage annually, not to exceed 5.5% of the total wages paid to employees in the State during each calendar year. Payroll tax revenue is to be collected by DLLR.

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 the 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 (HSCRC) to provide reimbursement for uncompensated care.

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.

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 $107.8 million. This estimate reflects the following facts and assumptions:

- a 50-cent excise tax on cigarettes generates $95.25 million additional revenue;
- a 50-cent floor tax on existing cigarette inventory generates $11.2 million; and
- the excise tax increases sales tax on cigarettes by $1.36 million.

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.

Payroll Tax: The bill requires an employer with fewer than 10,000 employees to pay a 4.5% payroll tax on its employees' wages. A nonprofit employer with 10,000 or more employees must pay a 6% payroll tax, and a for-profit employer with over 10,000 employees must pay an 8% payroll tax. 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 $4.6 billion and $8.1 billion in additional revenue. 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 $0 to $1.7 billion. It is assumed that most employers with fewer than 10,000 employees would provide health

insurance for their employees to fully offset the payroll tax. However, large businesses subject to the payroll tax may not spend enough to offset the tax and would therefore bear most of the tax's cost. 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 these entities and subsequently how much payroll tax they would pay.

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 2002 was $39,360, significantly higher than the 2004 FPG rate of 350%, which is $32,585. 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.

MCHP Premium Revenue: MCHP special fund revenues could increase by $1,099,844 in fiscal 2005, which assumes the MCHP expansion would begin January 1, 2005. This estimate assumes 1,898 kids between 300% FPG and 400% FPG enroll and pay a $637 annual premium and 1,898 kids over 400% FPG enroll and pay a $1,146 annual premium. Future year estimates reflect 5% enrollment growth and 6.5% medical inflation in the Medicaid program.

State Expenditures:

Medicaid: Medicaid expenditures could increase by an estimated $98,217,265 in fiscal 2005, which assumes waiver approvals and that enrollment begins January 1, 2005. This estimate reflects covering 19,683 individuals in fiscal 2005 under Medicaid and MCHP, an additional 60,394 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 15,888 new individuals at $3,000 per enrollee in fiscal 2005;
- MCHP premium expansion covers 3,795 new kids in fiscal 2005 at $1,200 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 60,394 new individuals in fiscal 2005 at $713 per enrollee;
- Medicaid enrollees do not have cost sharing;

- MCHP enrollees with incomes over 200% FPG pay premiums ranging from $637 to $1,146 annually, depending on income;
- specialty mental health coverage for approximately 20%, or 3,487 new enrollees costs $4,556 per adult and $5,013 per child;
- MPCP general fund expenditures decrease by at least $7.1 million from reduced enrollment;
- MPAP expenditures decrease by $16,189,872 from reduced enrollment; and
- administrative costs increase by $7,501,439 in fiscal 2005 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, 6.5% 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.

Maryland Health Care Commission: MHCC special fund expenditures could increase by an estimated $335,455 in fiscal 2005, which accounts for the bill's October 1, 2004 effective date. 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	$124,992
Consultant Contract for Data Collection	200,000
Operating Expenses	10,463
Total FY 2005 State Expenditures	**$335,455**

Future year expenditures reflect: (1) full salaries with 4.5% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

DLLR Administration of the 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. 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.

Other Expenditures: MDCare must provide health insurance coverage to an uninsured individual with specified incomes. 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:

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: A similar bill, SB 557, was introduced in 2003. It was reported unfavorably by the Senate Finance Committee.

Cross File: HB 1008 (Delegate Hubbard, *et al.*) – Health and Government Operations.

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

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