HB 568

Department of Legislative Services

Maryland General Assembly
2006 Session

FISCAL AND POLICY NOTE

House Bill 568 (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 $1.0 million annually from the Cigarette Restitution Fund (CRF) to fund the office.

The bill takes effect July 1, 2006.

Fiscal Summary

State Effect: Special fund expenditures could increase by $1.0 million annually beginning in FY 2007 to fund the office, assuming a sufficient CRF fund balance. No effect on revenues.

($ in millions)	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Revenues	$0	$0	$0	$0	$0
SF Expenditure	1.0	1.0	1.0	1.0	1.0
Net Effect	($1.0)	($1.0)	($1.0)	($1.0)	($1.0)

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 program must 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
- community-based organizations and other health care providers that demonstrate the capacity for reducing health care disparities that use interventions listed in the Department of Health and Mental Hygiene's (DHMH) plan to reduce health care disparities.

The office must: (1) establish the criteria for a group or provider to qualify for a grant; (2) establish an evaluation system of grantees that includes the collection of process and outcome data to determine the efficacy of the programs; and (3) require grantees to comply with the evaluation system developed by the office and provide quarterly reports on the grantee's 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 the grants.

Funding for the Office of Minority Health and Health Disparities must come from the CRF. For each fiscal year for which appropriations are made, at least $1 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 2008. The bill adds that it is the General Assembly's intent that the office be funded with CRF funds as well as the federal and special funds listed under statute.

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 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 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.

By the fifteenth day of each regular session of the General Assembly, DHMH must submit an annual report on the office to the Governor and the General Assembly on: (1) the projects and services developed and funded by the office and the health care problems the grant funds are intended to ameliorate; and (2) any recommendations for administrative or legislative action it deems appropriate. It is the General Assembly's intent that the office be funded with federal and special funds.

The CRF is a special, nonlapsing fund supported by revenue from a settlement with the five major tobacco companies. The CRF 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 made for these programs.

Background: The Office of Minority Health and Health Disparities *Fiscal Year 2005 Annual Report* states that African American death rates from 2001 through 2003 exceeded white death rates in the 22 Maryland jurisdictions where age-adjusted rates could be calculated.

The Behavioral Risk Factor Surveillance System survey from 2001 through 2004 shows that, in Maryland, African American and Hispanic adults have higher rates of diagnosed diabetes than white adults and, in the middle age and the older age groups, African American adults have higher rates of diagnosed hypertension than white adults, according to the report. Also, Maryland adults of all racial and ethnic minority groups were more likely to be without health insurance and were more likely to be unable to afford to see a doctor than white adults.

Over the last 11 years, the report found that the rates of new cases of end-stage renal disease (kidney disease) in Maryland were about three times higher for African Americans and Native Americans than for whites.

In 2003, when compared to white women, the percentage of births to women receiving late or no prenatal care was approximately three times higher for African American and Hispanic women, about two times higher for Native American women, and about 50% higher for Asian women.

In December 2005, the office released a series of recommendations for addressing minority health disparities within the State in four areas: access to quality health

services, health professional education, identifying funding strategies, and measuring health disparities.

Among the recommendations for identifying funding strategies was a recommendation for the State to allocate funds and otherwise support educational, health care, and regulatory institutions promoting health careers and offer cultural competency training programs. Another recommendation was for the State to allocate funds for data collection, analysis, and reporting on minority groups who are underrepresented in existing epidemiological reports; *e.g.* Native Americans, Asians, and Hispanics.

Racial Disparities Nationwide

Racial disparities in the provision and quality of health care have long been documented. One report on the subject indicates that racial and ethnic disparities persist in health care for a number of medical conditions and services, even when comparing individuals of similar income and health insurance coverage.

Racial and ethnic differences are apparent when looking at the percentage of individuals who have no health insurance. As illustrated in **Exhibit 1**, in 2003, 13% of whites lacked health insurance, while the uninsured rates for minorities ranged from 20% to 34%.

Exhibit 1
Nonelderly Uninsured by Race/Ethnicity, 2003*

Race/Ethnicity	Uninsured Rate
White (non-Latino)	13%
Asian/Pacific Islander	20%
African American (non-Latino)	21%
American Indian/Alaskan Native	28%
Latino	34%
National Rate	18%

*Kaiser Commission on Medicaid and the Uninsured/Urban Institute 2004

The availability of health care providers in a community also impacts the care obtained. Minorities are more likely to live in medically underserved areas that lack adequate health care sources. Twenty-eight percent of Latinos and 22% of African Americans report having little or no choice in where to seek care, while only 15% of whites report this difficulty. When minorities are able to find accessible health care providers, language

and cultural barriers sometimes present difficulties. Approximately 30% of Latinos say they have had a problem communicating with health care providers.

While the gaps in quality of care among races have decreased over the past several years, African Americans are still getting far fewer operations, exams, medications, and other treatments than whites. One study published in the *New England Journal of Medicine* measured gaps in care provided to whites and African Americans, looking at such screenings and treatments as breast cancer screening, diabetes care, beta blocker prescriptions after myocardial infarction, and cholesterol management after myocardial infarction or coronary procedures. Over the seven-year period studied, quality of care increased for both whites and blacks, and disparity gaps decreased. However, African Americans still received less treatment than whites, particularly related to cholesterol management.

Significant Reductions in CRF Funding Possible

Recent actions by several subsequent participating manufacturers threaten to reduce the amount of revenue available to the states. These manufacturers contend that manufacturers not participating in the Master Settlement Agreement have exploited legal loopholes to reduce their payments to the states, giving those manufacturers a competitive advantage in the pricing of their products. Approximately $84 million has been placed in escrow by the subsequent participating manufacturers pending resolution of the dispute by an arbitration. This amount, as well as $105 million overdue from the manufacturers, has reduced revenue immediately available to the State of Maryland by $4 million.

The possibility remains that additional companies, including the four original participating manufacturers, will withhold funds based on loss of market share. The Master Settlement Agreement authorizes manufacturers that lose a certain share of the market to withhold three times the amount of their losses. Based on preliminary estimates, an action of this sort has the potential to reduce payments under the Master Settlement Agreement by up to $1.1 billion or 18%, of which Maryland's share is approximately $26 million. The reduction would be applied to the fiscal 2006 payment due April 15, 2006. Industry leaders are in the process of reviewing past payments to determine the amount of losses.

It is difficult to anticipate at this time the magnitude or timing of challenges to payments under the Master Settlement Agreement. The nature of these disputes may vary based on state laws, the level of enforcement, and the amount of competition from nonparticipating manufacturers; likewise, the timeline and ultimate disposition of these cases will likely vary by jurisdiction.

State Fiscal Effect: Special fund expenditures could increase by $1 million in fiscal 2007, which accounts for a 90-day start-up delay. This estimate reflects the cost of grants to community-based organizations, historically black colleges and universities, and health care providers and for hiring a program administrator and secretary to administer the grant program. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Health Disparities Grants	$908,579
Salaries and Fringe Benefits	76,780
Operating Expenses	14,641
Total FY 2007 State Expenditures	**$1,000,000**

Future year expenditures reflect: (1) full salaries with 4.6% annual increases and 3% employee turnover; (2) 1% annual increases in ongoing operating expenses; (3) an assumption that there will be a CRF fund balance of at least $1 million; and (4) the bill's prohibition against diverting CRF funds from other programs.

DHMH advises that although statute requires the office to provide grants to reduce or eliminate racial and ethnic disparities contingent on funding availability, funds have not been appropriated in the State budget for this purpose.

To the extent that Master Settlement Agreement 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 Master Settlement Agreement payments, little if any funding would be available to implement this bill.

Estimated CRF Fund Balances

FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
$2.5 million	$3.3 million	$4.8 million	$3.2 million	$2.2 million

Source: Department of Budget and Management

Additional Information

Prior Introductions: None.

Cross File: SB 937 (Senator Exum) – Education, Health, and Environmental Affairs; and Budget and Taxation.

Information Source(s): Governor's *Office; Policy Challenges and Opportunities in Closing the Racial/Ethnic Divide in Health* Care, Kaiser Family Foundation (March 2005); "Trends in the Quality of Care and Racial Disparities in Medical Managed Care," *New England Journal of Medicine* (August 18, 2005); *Fiscal Year 2005 Annual Report*, Office of Minority Health and Health Disparities, January 2006; *Statewide Health Disparities Committees Executive Summary and Recommendations for The Maryland Plan to Eliminate Minority Health Disparities*, Office of Minority Health and Health Disparities, December 2005; Department of Health and Mental Hygiene; Department of Legislative Services

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