SB 813

Department of Legislative Services

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FISCAL AND POLICY NOTE

Senate Bill 813 (Senator Jones)
Finance and Budget and Taxation

Health Care Affordability Act of 2009

This bill proposes a significant restructuring of Maryland's health care system, including establishing the Maryland Health Insurance Pool, imposing an individual health insurance mandate, and expanding eligibility for Medicaid. These efforts are funded by a 2% payroll tax on employers, an increase in alcoholic beverage and tobacco taxes, tax penalties on individuals who do not obtain health insurance, a fee on pharmaceutical manufacturers and labelers, and reallocated funding from other programs.

The bill has multiple effective dates beginning with July 1, 2009. The income tax penalty provisions take effect January 1, 2010, and are applicable beginning with tax year 2010.

Fiscal Summary

State Effect: General fund revenues increase by $14.9 million from tobacco tax revenues in FY 2010. Special fund revenues increase by an estimated $2.6 billion in FY 2010, including $2.3 billion from a 2% payroll tax, $206.9 million from increased alcoholic beverage taxes (which may be partially offset by a reduction in sales tax revenues), and $71.9 million from increased tobacco taxes. Special fund revenues increase by a potentially significant amount beginning in FY 2011 from tax penalties on individuals who do not obtain health insurance. Medicaid expenditures increase by at least $670.4 million ($276.6 million in special funds) in FY 2010. Additional significant special fund expenditures are anticipated, including $234.7 million in mandated expenditures in FY 2010. **This bill establishes multiple mandated special fund appropriations beginning in FY 2011.**

Local Effect: Local jurisdiction expenditures increase under the 2% payroll tax, but may be offset by reductions in health care expenditures. **This bill imposes a mandate on a unit of local government.**

Small Business Effect: Meaningful. Small business expenditures increase under the 2% payroll tax (or penalties for failure to pay the tax). Small business health insurance expenditures may increase or decrease under the bill depending on the combined impact of the Maryland Health Insurance Pool and the Catastrophic Reinsurance Benefit Plan.

Analysis

Bill Summary: The bill also (1) creates the Catastrophic Reinsurance Benefit Plan; (2) establishes the Maryland Institute for Clinical Value, the Value-Based Advisory Committee, and the Citizens' Advisory Council; (3) implements an electronic health record system; (4) establishes a Maryland Prevention Trust for Health Promotion; (5) establishes an Evidence-Based Prescriber Education and Outreach Program; and (6) creates a Healthy Maryland Fund.

Maryland Health Insurance Pool: The bill establishes the Maryland Health Insurance Pool as an independent unit of State government governed by a Board of Directors to act as a mechanism for purchasers in the individual and small group insurance markets to obtain affordable health care coverage. The bill repeals the Maryland Health Insurance Plan (the State's high-risk pool) and instead merges the individual and small group health insurance markets within the pool.

Each health benefit plan offered through the pool must be offered on a guaranteed-issue and guaranteed-renewal basis, with no preexisting condition limitations or medical underwriting. Community rating must be used for all health benefit plans, without regard to any factor other than age. Carriers may charge a rate that is 50% above or below the community rate. Rates may vary based on family composition.

Eligibility is open to (1) individuals without access to employer-sponsored coverage; (2) employers with less than 100 employees; (3) certain large employers (100 or more employees); and (4) dependents of individuals eligible for participation. Large employers are eligible only if they agree not to offer any separate or competing health benefit plan or if the coverage they offer does not provide benefits that are at least actuarially equivalent to the benefits in the basic plan offered through the pool.

Beginning January 1, 2011, the pool must be the sole mechanism for creditable coverage for an individual without access to employer-sponsored coverage and employees of small employers. A carrier may only insure or offer to insure an individual without access to employer-sponsored coverage or an employee of a small employer as a participating carrier in the pool.

The pool must offer, through its participating carriers, multiple health benefit plans for choice by individual enrollees. Plans must be classified as a basic plan, a typical plan, or a generous plan. All carriers must offer at least a basic plan. The board may require each participating carrier to offer other health benefit plans, in addition to a basic plan. Health benefit plans must incorporate chronic care improvement and preventive health measures.

Participating carriers have to make certain information available to enrollees upon enrollment and annually thereafter. Carriers also must disclose to the board the medical loss ratio experienced across all the health benefit plans the carrier offers through the pool. By January 1, 2016, the board must review carriers' medical loss ratios, determine whether a public health benefit plan option is feasible and desirable, and report its findings. The board must also determine whether adverse selection is occurring. If adverse selection is impacting the pool, the board may establish an annual open enrollment period; impose a surcharge of up to 5% of premium; or impose a preexisting condition limitation of up to six months for nonemergency services for those individuals entering the pool who have had a break in creditable coverage exceeding 63 days.

The pool must subsidize coverage for enrollees that (1) have family incomes up to 400% of federal poverty guidelines (FPG); and (2) are either without access to employer-sponsored coverage or are employed by a small employer (less than 100 employees) that participates in the pool. Individuals employed by large employers are not eligible for a subsidy. For an enrollee with family income below 300% FPG, the subsidy is 50% of the average premium for the enrollee's age in a typical plan. For an enrollee with family income that is between 300% and 400% FPG, the subsidy is 25% of the average premium for the enrollee's age in a basic plan.

Individual Mandate for Health Insurance Coverage: Each taxpayer has to indicate on the State income tax return the presence of health care coverage for the individual, each spouse in the case of a married couple, and each dependent child. If a taxpayer and each dependent child do not maintain continuous health care coverage during the taxable year, the taxpayer must pay a tax penalty. For tax year 2010, the penalty is 10% of the average premium that the taxpayer would pay for a basic plan offered through the pool or, for a married couple filing a joint return, 10% of the average premium for a basic plan that covers both spouses and any dependent children who lack creditable coverage. For tax year 2011, the penalty is 30% of the average premium. For tax year 2012 and subsequent years, the penalty is 50% of the average premium.

The Comptroller must provide for exceptions for (1) individuals eligible for, but not enrolled in Medicaid; (2) individuals with household incomes below 300% FPG if the cost of coverage would exceed 5% of federal adjusted gross income (FAGI); (3) individuals with household incomes between 300% and 500% FPG if the cost of

coverage would exceed 7.5% of FAGI; and (4) individuals with household incomes above 500% FPG if the cost of coverage would exceed 10% of FAGI.

The Comptroller must publicize the income tax requirements of the bill to provide an adequate opportunity for individuals to obtain health care coverage and avoid penalties. The Comptroller may deduct reasonable administrative costs from the tax penalty revenues and must submit the remaining revenues to the Healthy Maryland Fund.

Catastrophic Reinsurance Benefit Plan: The bill creates a Catastrophic Reinsurance Benefit Plan, administered by the board, to make health insurance more affordable by removing a portion of the cost of high-cost health care from the health insurance premium. Participation is mandatory for (1) all carriers; (2) the State Employee and Retiree Health and Welfare Benefits Program (the State plan); (3) county employee health benefits programs; and (4) county school system employee health benefits programs. Participation is voluntary for self-insured plans. The board must contract with private reinsurance carriers to provide reinsurance benefits through the plan to reduce the cost of health insurance premiums by 10%. Reinsurance benefits must include subsidies for health insurance claims that exceed specified attachment points and case management services for individuals whose health care costs indicate a need for the services. The cost of reinsurance benefits must be funded by the Healthy Maryland Fund.

Medicaid Eligibility: Medicaid eligibility is expanded, beginning July 1, 2009, to (1) parents and caretaker relatives who have a dependent child living in the home and annual household income up to 300% FPG; and (2) childless adults with annual household incomes at or below 200% FPG. Parents or caretaker relatives with annual household income between 200% and 300% FPG must pay a $50 per month premium that cannot exceed 4% of household income.

Individuals eligible for Medicaid who are offered employer-sponsored health insurance may remain in Medicaid or opt for premium assistance. If an individual is offered employer-sponsored health insurance from an employer with more than 100 employees, Medicaid must pay 100% of the employee share of the premium. If the employer has 100 or fewer employees, Medicaid must pay a specified subsidy. Individuals eligible for Medicaid who do not have access to employer-sponsored health insurance may remain in Medicaid or opt for premium assistance for coverage under the pool.

Maryland Institute for Clinical Value: The Maryland Institute for Clinical Value will develop and implement policies that direct health care spending toward evidence-based services that provide significant benefit and value to consumers and improve public health. The institute must (1) adopt best practices; (2) use clinical and economic assessments; (3) identify priorities for implementation; (4) coordinate implementation efforts; (5) develop patient cost-sharing and provider reimbursement policies for health

care services covered by participating carriers in the pool; (6) identify and fund research initiatives; (7) publicize and disseminate its policies and strategies; (8) subsidize electronic health record systems for hospitals and physician group practices; and (9) support the cost of a statewide health information exchange.

The bill establishes two advisory entities within the institute. The Value-Based Advisory Committee will review and approve the institute's policies and guidelines. The Citizens Advisory Council will promote citizen participation in health care reform efforts by establishing a dispute resolution process and producing annual recommendations for improving the operation of the pool.

Maryland Prevention Trust for Health Promotion: The Maryland Prevention Trust for Health Promotion, part of the institute, will reduce health disparities through grants, programs, and initiatives, including (1) funding the Office of Minority Health and Health Disparities to create a Minority and Low-Income Health Report Card; (2) grants to establish a Maryland Racial and Ethnic Approaches to Community Health (REACH) community action program; and (3) funding an advance directives registry.

Evidence-Based Prescriber Education and Outreach Program: An Evidence-Based Prescriber Education and Outreach Program is created in the Department of Health and Mental Hygiene (DHMH) to improve health outcomes and reduce unnecessary costs by ensuring that health care professionals have evidence-based information available to support prescribing decisions. Beginning April 1, 2011, DHMH, in consultation with specified entities and subject to the availability of funds, must work with the University of Maryland School of Pharmacy to develop, implement, and promote the program. DHMH may contract with the School of Pharmacy to administer the program, which must provide information and education to health care professionals who participate in, contract with, or are reimbursed by State health care programs.

An Evidence-Based Prescriber Education and Outreach Program Fund is established to support the program. The fund consists primarily of revenues from a new fee on pharmaceutical manufacturers and labelers. The fund may be used only for prescriber information, education, and outreach activities and program administration.

Fee on Pharmaceutical Manufacturers and Labelers: Beginning April 1, 2010, the bill requires each pharmaceutical manufacturer and labeler doing business in the State to pay an annual fee of $2,500 to DHMH. All fees must be deposited in the Evidence-Based Prescriber Education and Outreach Program Fund.

Healthy Maryland Fund: The bill creates a Healthy Maryland Fund to support specified programs and activities. The fund consists of revenues from (1) a payroll tax; (2) increases in the alcoholic beverage tax; (3) increases in tobacco taxes; (4) tobacco

settlement strategic contribution payments; and (5) the MHIP hospital assessment; as well as (6) money deposited by CareFirst into a separate account for the Senior Prescription Drug Assistance Program (SPDAP); (7) investment earnings; and (8) any other money accepted for the benefit of the fund.

The fund may be used only for (1) subsidies and associated administrative costs for the pool; (2) reinsurance benefits and associated administrative costs for catastrophic reinsurance; (3) specified Medicaid expenses including eligibility expansion, premium assistance for individuals who choose employer-sponsored insurance, a new Medicaid eligibility determination system, additional eligibility caseworkers, and an expanded Medicaid benefit package; (4) the activities of the institute; (5) expansion of substance abuse treatment services through the Alcohol and Drug Abuse Administration (ADAA) for adults and adolescents without access to third-party coverage for these services; and (6) SPDAP.

Payroll Tax: Each employer must pay to the Secretary of Labor, Licensing, and Regulation an amount equal to 2% of the total wages paid to part-time and full-time employees in the State, excluding wages in excess of the Social Security wage base limit. An employer may not deduct any payment from the wages of an employee. Failure to make the payment is subject to a civil penalty of up to $250,000. The Secretary must adopt regulations to implement the payroll assessment and pay the revenue into the Healthy Maryland Fund.

Alcoholic Beverage Taxes: The bill increases alcoholic beverage tax rates to $10.03 per gallon for distilled spirits, $2.96 per gallon for wine, and $1.16 per gallon for beer. The Comptroller must distribute 100% of the additional revenue resulting from the increases to the Healthy Maryland Fund.

Tobacco Taxes: The tax on cigarettes is increased from $2.00 to $2.75 per pack and a floor tax is imposed on cigarettes used, possessed, or held in the State effective July 1, 2009. The tobacco tax rate for other tobacco products is increased from 15% to 90% of the wholesale price. The bill sets the amount of tobacco tax revenues distributed to the general fund at $419.0 million annually and requires all revenue above this amount to be distributed to the Healthy Maryland Fund. Beginning July 1, 2012, the cigarette tax is further increased to $3.025 per pack. No floor tax provision is included for fiscal 2013.

Tobacco Settlement Bonus Payments: Money from the Cigarette Restitution Fund (CRF) is authorized for use to support programs and activities supported by the Healthy Maryland Fund. Beginning in fiscal 2010, any revenue realized by CRF from strategic contribution payments must be deposited into the Healthy Maryland Fund.

Current Law:

Individual Mandate for Health Insurance Coverage: There is no mandate that individuals maintain health insurance for themselves or their dependents. Chapter 692 of 2008 requires taxpayers to indicate on their income tax return whether each dependent child for whom an exemption is claimed has health care coverage. For tax years 2008 and 2009, the Comptroller must send taxpayers with a dependent child and incomes up to the highest income eligibility standard for Medicaid or the Maryland Children's Health Program (MCHP) a notice that their dependent child may be eligible for Medicaid or MCHP, including how to enroll in the programs. Chapter 692 terminates June 30, 2011.

Medicaid and MCHP: Medicaid provides health care coverage to approximately 590,000 Marylanders. Eligibility is limited to children, pregnant women, elderly or disabled individuals, and certain parents and caretaker relatives. Chapter 7 of the 2007 special session expanded eligibility for Medicaid to parents, caretaker relatives, and childless adults with incomes up to 116% FPG effective July 1, 2008.

MCHP offers comprehensive health care coverage to low-income children younger than age 19 with family incomes that exceed the standard for Medicaid but are at or below 300% FPG. Children in families with incomes above 200% but at or below 300% FPG are enrolled in the MCHP Premium Plan. These families pay a family contribution toward the cost of the program equal to 2% of the annual income for (1) a family of two at 200% FPG (about $576 per year), for families earning up to 250% FPG; or (2) a family of two at 250% FPG (about $720 per year), for families earning up to 300% FPG. Individuals who have been eligible for employer-sponsored health insurance in the previous six months are ineligible for MCHP.

Maryland Health Insurance Plan: MHIP is an independent unit of State government. The purpose of MHIP is to decrease uncompensated care costs by providing access to affordable, comprehensive health benefits for medically uninsurable residents. Medical eligibility for the program requires that applicants have been denied individual coverage, have been offered coverage that excludes or limits coverage for a medical condition, or have specific health conditions. Members pay a premium based on age, subscriber type, and type of benefit plan. Individuals with incomes below 300% FPG may receive discounted premiums through MHIP+. MHIP currently has 15,180 enrollees.

Small Group Market: The Comprehensive Standard Health Benefit Plan (CSHBP) is a standard health benefit package that carriers must sell to small businesses (2 to 50 employees). CSHBP includes guaranteed issuance and renewal, adjusted community rating with rate bands, and the elimination of preexisting condition limitations. CSHBP has a minimum benefit floor based on the actuarial value of a federally qualified health maintenance organization (HMO) and an affordability ceiling

based on the average premium of all policies expressed as a percentage of the average wage in Maryland. Carriers must use a community rate that is based on the experience of all risks covered by that health benefit plan without regard to health status or occupation. The rate may only be adjusted for age and geographical location. Carriers may charge a rate that is 40% above or 50% below the community rate and offer a discounted rate of up to 20% to a small employer for participation in a wellness program.

Advance Directive Registry: Chapter 223 of 2006 established an Advance Directive Registry in DHMH and required the Maryland Department of Transportation to add an advance directive notation on driver's licenses and identification cards. The registry has not yet been implemented.

Alcoholic Beverage Taxes: State tax rates for alcoholic beverages in Maryland are $1.50 per gallon for distilled spirits, $0.40 per gallon for wine, and $0.09 per gallon for beer. Total estimated revenues from all alcoholic beverage taxes are estimated to be $29.6 million in fiscal 2010. The tax on distilled spirits has not increased since 1955, and the tax on beer and wine was last increased in 1972.

Tobacco Tax Rates: State tax rates for cigarettes are $2.00 per pack. The tax rate on other tobacco products is 15% of the wholesale price. The tax on cigarettes was increased from $1.00 to $2.00 by Chapter 6 of the 2007 special session. The federal cigarette excise tax will increase to $1.00 on April 1, 2009, as part of recently enacted federal legislation reauthorizing the State Children's Health Insurance Program.

Cigarette Restitution Fund: Chapter 173 of 1999 established CRF, which is supported by payments made under the Master Settlement Agreement (MSA). Through MSA, the settling manufacturers will pay the litigating parties approximately $206 billion over the next 25 years and beyond, as well as conform to a number of restrictions on marketing to youth and the general public. Maryland receives 2.26% of MSA monies which are adjusted for inflation, volume, and prior settlements. In addition, the State will collect 3.30% of monies from the Strategic Contribution Fund, distributed according to each state's contribution toward resolution of the state lawsuits against the major tobacco manufacturers. The use of CRF special funds is specified in statute.

Background:

Employer-based Health Care Coverage in Maryland: According to the Maryland Health Care Commission (MHCC), 71% of nonelderly insured individuals in the State had employer-based health insurance (about 3.5 million individuals) and 7% had direct purchase insurance (about 346,000 individuals) in 2006-2007. Access to employer-based insurance has declined from 78% in 2000-2001.

Uninsured in Maryland: According to MHCC, 15.4% of Maryland's nonelderly population was uninsured in 2006-2007, with an average of 760,000 uninsured nonelderly residents per year (610,000 adults and 150,000 children). Maryland's nonelderly uninsured rate is consistently lower than the national average of 17.5% due to greater employment-based coverage. Persons in families with incomes below 200% FPG form a minority (44%) of Maryland's uninsured. About 60% of Maryland's uninsured are employed adults.

Massachusetts Health Reforms: Massachusetts' major reform efforts in 2006 (1) expanded children's Medicaid eligibility to 300% FPG; (2) raised enrollment caps for a number of Medicaid programs; (3) established the Commonwealth Care program to provide subsidized coverage to low-income adults below 300% FPG; (4) merged the individual and small group markets; (5) required all adults to have health insurance if affordable coverage is available or pay tax penalties; (6) required employers with 11 or more employees to make a "fair and reasonable contribution to coverage" or pay a $295 assessment per worker each year; and (7) established the Commonwealth Health Insurance Connector to enable people with incomes above 300% FPG to purchase standardized private insurance plans.

Massachusetts has experienced budget difficulties due to the health care expansion, mainly due to the higher-than-expected number of enrollees in free or subsidized programs and lower-than-expected revenues from employer assessments. In July 2008, the state increased its cigarette tax by $1.00 per pack (to a total of $2.51) to help offset higher-than-anticipated costs of the state's coverage efforts. Regulations governing the employer assessment have also been expanded to further increase available revenues.

Health Care Reform in Other States: Vermont requires employers to provide coverage but does not require individuals to purchase health insurance. Vermont opened its subsidized health plan, Catamount Health, in November 2007. In May 2006, Vermont had approximately 67,000 uninsured residents. As of September 2008, approximately 6,000 individuals had enrolled in Catamount Health.

Approaches have varied in other states, but most states, like Maryland, have taken an incremental approach. Connecticut and Florida have created lower-cost health care policies that do not provide a full range of benefits. Connecticut created the Charter Oak Health Plan for adults that have not had health insurance for six months. The plan is offered by several insurers, and the state provides premium subsidies for low-income adults. Florida allows low-cost, reduced benefit policies to be sold to nonelderly uninsured adults who are not eligible for public insurance. Insurers may not reject applicants for the policies based on age or health status.

Maryland Citizens Health Initiative: The bill represents the "Health Care for All" plan of the Maryland Citizens' Health Initiative (MCHI). By MCHI's own estimates, the bill will result in $15.5 billion in new health care spending over five years (fiscal 2010 through fiscal 2014) and is intended to be self-funding through multiple revenue sources with no net impact on the general fund.

State Fiscal Effect: Given the complexity and far reaching effects of the bill, the complete fiscal effect cannot be reliably estimated given existing time constraints. Preliminary estimates of *known* potential revenues and expenditures are provided.

State Revenues: The bill's varied expenditures are funded by a 2% payroll tax on employers, an increase in alcoholic beverage and tobacco taxes, tax penalties on individuals who do not obtain insurance, a fee on pharmaceutical manufacturers and labelers, and reallocated funding from tobacco settlement bonus payments and MHIP. **Exhibit 1** summarizes the major revenue sources proposed under the bill.

Payroll Tax: Special fund revenues increase by at least $2.3 billion in fiscal 2010 from a 2% payroll tax on all employers. This estimate is based on 2005 Social Security Administration wage data for total wages under the wage base limit, including self-employed individuals. It is assumed that total wages and wages under the wage base limit have increased since 2005, so actual revenues will be greater.

Payroll tax revenues will be offset by anticipated reductions in corporate and personal income tax revenues. Businesses, including sole proprietors, S corporations, and limited liability corporations, can deduct at least a portion of the payroll tax from their income tax. The exact amount of these offsets cannot be reliably estimated at this time but is anticipated to be significant. To the extent employers do not comply with the payroll tax, special fund revenues will increase from civil penalties of up to $250,000, which the Secretary of Labor, Licensing, and Regulation is authorized to impose.

Exhibit 1
Proposed Revenue Sources under SB 813/HB 951 of 2009
($ in millions)

Source	Change	Fiscal 2010 Revenues
Payroll Tax	2% of wages under the Social Security wage base limit	$2,290
Alcoholic Beverage Taxes	Distilled spirits from $1.50 to $10.03/gallon	67.8
	Wine from $0.40 to $2.96/gallon	32.4
	Beer from $0.09 to $1.16/gallon	106.6
Tobacco Taxes	Cigarette tax from $2.00 to $2.75 per pack (7/1/09)	55.5
	Other tobacco products from 15% to 90% of wholesale price	23.1
	Floor tax (one-time-only revenues in fiscal 2010)	13.2
	Cigarette tax from $2.75 to $3.025 per pack (7/1/12)	0.0[1]
Tax Penalties (individuals who do not obtain health insurance)	10% of the average premium for a basic plan in the Maryland Health Insurance Pool (tax year 2010)	0.0[2]
	30% of the average premium for a basic plan in the pool (tax year 2011)	0.0[2]
	50% of the average premium for a basic plan in the pool (tax year 2012 and thereafter)	0.0[2]
Tobacco Settlement Bonus Payments	Authorizes use for the Healthy Maryland Fund (currently used for a variety of Cigarette Restitution Fund activities and Medicaid)	28.3
Maryland Health Insurance Plan (MHIP) hospital assessment	Redirects funding from the 1% assessment on the hospital all-payor system to the Healthy Maryland Fund beginning in fiscal 2010. The assessment currently funds MHIP.	114.9
Fee on pharmaceutical manufacturers and labelers	$2,500 fee, effective April 1, 2010	Indeterminate
Total		**$2,732**

[1] Revenues from the second cigarette tax increase begin in fiscal 2013.
[2] Revenues from the tax penalties begin in fiscal 2011.

Alcoholic Beverage Taxes: Special fund revenues increase by an estimated $206.9 million beginning in fiscal 2010 from increased taxes on distilled spirits ($67.9 million), wine ($32.4 million), and beer ($106.6 million). While revenues increase significantly from a substantial increase in tax rates, sales of alcoholic beverages are estimated to decline based on units sold by 17.1% for distilled spirits, 4.3% for wine, and 3.6% for beer. Future year revenues are anticipated to grow by 2.0% annually.

The total increase in alcoholic beverage tax revenues may be offset by a reduction in sales tax revenues. As noted, the increased tax on alcoholic beverages results in a decline in demand for these products. Accordingly, sales tax revenues will decrease. It is assumed that the price increase attributable to the increased tax rate will be passed along to the end consumer, resulting in a higher retail price for alcoholic beverages. This may, to some degree, mitigate the decrease in sales tax revenues resulting from the tax increase proposed by the bill.

Tobacco Taxes: Total State revenues increase by an estimated $91.8 million beginning in fiscal 2010 from increased taxes on cigarettes ($55.5 million) and other tobacco products ($23.1 million), including one-time floor tax revenues ($13.2 million). While revenues increase from higher tax rates, sales of tax paid cigarettes are estimated to decline by 17% in fiscal 2010. Sales of other tobacco products are estimated to decline by 49%. A decline in sales of tobacco products results in reduced sales tax revenues of approximately $5.0 million in fiscal 2010.

The bill requires that $419.0 million in tobacco tax revenues be transferred to the general fund annually before additional revenues are transferred to the Healthy Maryland Fund. Thus, in fiscal 2010, only $71.9 million of the $91.7 million in new revenues accrues to the Healthy Maryland Fund. The remaining $19.9 million in new revenues accrues to the general fund to achieve the tobacco tax revenue "floor" of $419.0 million. However, these additional tobacco tax revenues are offset by $5.0 million in reduced sales tax revenues, resulting in a net impact on the general fund of $14.9 million in fiscal 2010.

Beginning in fiscal 2012, the cigarette tax is further increased to $3.025 per pack. Sales of tax paid cigarettes are estimated to decline by 9% in fiscal 2012. Total revenues of $76.1 million are anticipated in fiscal 2012, with $49.0 million going to the Healthy Maryland Fund and a net impact to the general fund of $27.2 million.

Tax Penalties: Special fund revenues increase by a potentially significant amount beginning in fiscal 2011 from tax penalties imposed on individuals and married couples that do not obtain health insurance for themselves and their dependent children. The exact amount of revenues will depend on the number of individuals who do not obtain health insurance, the cost of the average premium for a basic plan in the newly

created pool, and the number of individuals who will qualify for one of the bill's exceptions.

For illustrative purposes only, in the first year of its individual mandate (tax year 2007), Massachusetts collected approximately $16.0 million in revenues from taxpayers that did not obtain health insurance as required. The maximum penalty for tax year 2007 was $219 for an individual. For tax year 2008, the maximum penalty is $912 for an individual.

Fee on Pharmaceutical Manufacturers and Labelers: Special fund revenues for the Evidence-Based Prescriber Education and Outreach Program Fund increase beginning in fiscal 2010 as fees are collected from pharmaceutical manufacturers and labelers doing business in the State starting April 1, 2010. Legislative Services advises that revenue generated by assessing manufacturers is unlikely to cover program costs. The university estimates that fees may generate about $225,000 per year, which equates to 90 manufacturers and labelers paying the $2,500 fee. However, it is difficult to reliably estimate the number of manufacturers and labelers subject to the fee as Chapter 157 of 2002 eliminated the requirement for a State pharmaceutical manufacturing permit. Thus, the ability to track the number of manufacturers in the State was also eliminated; nevertheless, in 2001, 52 manufacturers held permits.

Reallocated Funding: In addition to establishing new revenues, the bill reallocates existing funding from tobacco settlement bonus payments and the 1% assessment on the hospital all-payor system that funds MHIP, which is repealed under the bill. Funds are redirected to the Healthy Maryland Fund. The Governor's proposed fiscal 2010 budget includes $28.3 million in tobacco settlement bonus payments, which are currently allocated for a number of CRF programs, including support of Medicaid. For fiscal 2010, the MHIP assessment is anticipated to generate $114.9 million.

State Expenditures: The bill's restructuring of Maryland's health care system requires significant expenditures from the Healthy Maryland Fund and the general fund to enforce the individual mandate for health insurance coverage; create and administer a Maryland Health Insurance Pool, a Catastrophic Reinsurance Benefit, the Maryland Institute for Clinical Value, and the Maryland Prevention Trust for Health Promotion; expand eligibility for Medicaid; implement electronic health records; and establish and administer an Evidence-Based Prescriber Education and Outreach Program. **Exhibit 2** summarizes major *known* expenditures anticipated under the bill in fiscal 2010. *Significant additional expenditures* will be required to implement the Maryland Health Insurance Pool (including subsidies for low-income individuals), the Catastrophic Reinsurance Benefit Plan, and the Maryland Institute for Clinical Value. Legislative Services cannot reliably estimate the funding required for these entities at this time.

Exhibit 2
Major Expenditures under SB 813/HB 951 of 2009
($ in Millions)

Fund Source and Program	Agency	FY 2010 Expenditure
All Funds		
State Share of Payroll Tax	DBM	$120.0
General Funds		
Collection of Payroll Tax	DLLR	7.1
Special Funds[1]		
Medicaid Expansion	DHMH	276.6
Programmatic Expenditures[2]	Various	234.7
Maryland Health Insurance Pool	New	-
Maryland Institute for Clinical Value	New	-
Catastrophic Reinsurance Benefit	New	-
Administration of Individual Mandate[3]	Comptroller	0.0
Evidence-Based Prescriber Program[4]	DHMH	0.0
Federal Funds		
Medicaid Expansion	DHMH	393.8
Total *Known* Expenditures[5]		**$1,032.2**

Notes: - = unknown impact. DBM = Department of Budget and Management. DLLR = Department of Labor, Licensing, and Regulation. DHMH = Department of Health and Mental Hygiene.
[1] From the Healthy Maryland Fund, with the exception of the Evidence-Based Prescriber Program.
[2] Includes mandated appropriations as displayed in Exhibit 3.
[3] Publicity of the mandate begins in fiscal 2010, but may be absorbable within budgeted resources. Additional expenses to alter tax forms and collect and audit penalties begin in fiscal 2011.
[4] Program to begin effective April 1, 2011 (fiscal 2011).
[5] Significant additional expenditures are anticipated but cannot be reliably estimated at this time.

Medicaid: Medicaid expenditures increase by a significant amount beginning in fiscal 2010 to expand eligibility to parents and caretaker relatives with incomes up to 300% FPG and childless adults with incomes at or below 200% FPG. Currently, these individuals are eligible only up to an income of 116% FPG. Medicaid has to collect a premium from parents and caretaker relatives with incomes between 200% and 300% FPG. A similar premium is currently collected for children enrolled in the MCHP Premium Plan. Medicaid also has to provide subsidies to individuals who opt to enroll in

available employer-sponsored health insurance or the Maryland Health Insurance Pool. The administrative cost to implement a premium assistance program cannot be reliably estimated at this time, but could be significant.

Initial one-time administrative and start-up costs to reprogram the Clients Automated Resource and Eligibility System (CARES) for the expanded eligibility group and to update the Medicaid Management Information Systems (MMIS) are anticipated to be $3.5 million in fiscal 2010 (approximately 47.5% general funds, 52.5% federal funds).

DHMH anticipates that 76,501 parents and caretaker relatives and 23,299 childless adults will enroll in Medicaid in fiscal 2010 under the expansion. To serve this population, Medicaid expenditures increase by a total of $693.9 million in fiscal 2010. This estimate includes $514.9 million in service costs for parents and caretaker relatives, $175.3 million in service costs for childless adults, $2.1 million to hire 36 additional administrative and eligibility staff, and $1.6 million in other administrative expenses such as enrollment broker and pharmacy costs. These expenditures will be offset by premium revenues from parents and caretaker relatives estimated to be $27.0 million in fiscal 2010, for a total net cost of $666.9 million. These expenditures do not include the cost to hire caseworkers at local departments of social services and local health departments, which are assumed to be covered by the bill's mandatory appropriations.

Some of the individuals eligible for Medicaid under the bill may have access to employer-sponsored health insurance. DHMH has to offer these individuals premium assistance either through their employer or in the Maryland Health Insurance Pool. To the extent that individuals eligible for Medicaid have access to other insurance and the cost of the subsidy (including the administrative costs to provide the subsidy) is less than the full cost to enroll the individual in Medicaid, total Medicaid expenditures will be reduced. Conversely, if the cost of the subsidy is greater than the cost to enroll those individuals in Medicaid, total Medicaid expenditures will be greater than estimated.

State Medicaid expenditures are assumed to be special funds from the Healthy Maryland Fund. The federal American Recovery and Reinvestment Act of 2009 allows states to draw down an enhanced federal matching rate. The enhanced match is based on each state's quarterly unemployment rate and will continue through fiscal 2010. Currently, the Maryland enhanced matching rate is estimated to be 58.78%. This rate may change during 2010, but all enhanced matching is slated to end in the second quarter of fiscal 2011. Therefore, Medicaid expenditures will increase by at least $276.6 million in special funds and $393.8 million in federal funds in fiscal 2010.

Payroll Tax: Department of Budget and Management expenditures increase by $120.0 million to pay the payroll tax assessed on 2% of wages. General fund expenditures for the Department of Labor, Licensing, and Regulation (DLLR) increase

by an estimated $13.1 million in fiscal 2010 to establish a new unit in DLLR to assess, collect, audit, and enforce the payroll tax requirements and to determine and assess civil penalties where necessary. Accounting, enforcement, and support services will cost approximately $7.1 million annually, while initial one-time start-up costs to acquire appropriate information technology will cost at least $6.0 million in fiscal 2010. As the Secretary of Labor, Licensing, and Regulation is not authorized to retain a portion of the funds collected for administration, Legislative Services assumes that general funds will be required for these expenditures.

Enforcement of the Individual Mandate for Health Insurance Coverage: Special fund expenditures for the Comptroller's Office increase beginning in fiscal 2011 to enforce the individual mandate for health insurance coverage. The Comptroller's Office will require additional compliance personnel, including one tax consultant and one revenue specialist in fiscal 2011 and one additional revenue specialist in both fiscal 2012 and 2013. By fiscal 2013, personnel expenses are estimated to be $268,797.

Beginning with tax year 2010, State income tax forms must be altered to collect information on whether each taxpayer, each spouse in the case of a married couple, and each dependent child has specified health care coverage, as well as to account for exceptions to the required coverage. Each additional line added to the tax form will require a one-time-only expense of $40,000. Legislative Services notes that Massachusetts requires residents to complete a three-page schedule that collects information on health insurance policies, allows indication of exemptions, and explains affordability guidelines. The schedule must be attached to the income tax return. To implement a similar schedule in Maryland would cost approximately $400,000, depending on the amount of information collected. As the bill authorizes the Comptroller's Office to deduct a reasonable amount for administrative expenses from the tax penalties, Legislative Services assumes that special funds will be used to implement and enforce the individual mandate.

The Comptroller must publicize the income tax requirements of the bill to provide an adequate opportunity for individuals to obtain health care coverage and avoid penalties. According to the Comptroller's Office, this can be accomplished within the income tax booklet, through other mailings the Comptroller is required to make, and through the Comptroller's website at minimal cost. To the extent additional publicity is required, additional special fund expenditures will be required.

Reallocated Funding: The bill reallocates existing funding from tobacco settlement bonus payments to the Healthy Maryland Fund. The Governor's proposed fiscal 2010 budget includes $28.3 million in tobacco settlement bonus payments, which are currently allocated for a number of CRF programs, including support of Medicaid. To the extent

funds that would otherwise be used for Medicaid are transferred to the Healthy Maryland Fund, general fund expenditures for Medicaid may increase beginning in fiscal 2010.

Programmatic Expenditures: Establishment of major health care entities, including the Maryland Health Insurance Pool, a Catastrophic Reinsurance Benefit, the Maryland Institute for Clinical Value, and the Maryland Prevention Trust for Health Promotion will require considerable special fund expenditures from the Healthy Maryland Fund. The Board of Directors of the Maryland Health Insurance Pool is required to spend significant funds on a variety of programs and initiatives summarized in **Exhibit 3**, including $234.7 million in fiscal 2010 alone. Legislative Services assumes that all of these mandated appropriations will be special funds from the Healthy Maryland Fund.

Exhibit 3
Mandatory Appropriations Under SB 813/HB 951 of 2009
Fiscal 2010-2014
($ in Millions)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Healthy Maryland Medicaid					
Medicaid eligibility determination system	$25.0	$25.0	$0.0	$0.0	$0.0
Additional caseworkers in local jurisdictions	10.0	10.0	10.0	10.0	10.0
Residential substance abuse treatment[1]	8.9	9.4	10.0	10.6	11.2
Maryland Institute for Clinical Value					
Research initiatives	10.0	5.0	2.5	2.5	2.5
Statewide health information exchange	20.0	0.5	0.5	0.5	0.5
Substance abuse treatment (ADAA)	10.0	10.0	10.0	10.0	10.0
Electronic health records[2]	59.0	0.0	0.0	0.0	0.0
Administrative costs	2.0	2.0	2.0	2.0	2.0
Prevention Trust for Health Promotion					
Local health department grants	5.0	5.0	5.0	5.0	5.0
Substance abuse prevention	10.0	10.0	10.0	10.0	10.0
Tobacco prevention and cessation	45.0	45.0	45.0	45.0	45.0
Community health centers	5.0	5.0	5.0	5.0	5.0
Tuition loan forgiveness	2.0	2.0	2.0	2.0	2.0
Training for health care workers	12.5	2.5	2.5	2.5	2.5
Health disparities	10.0	10.0	10.0	10.0	10.0
Advance Directives Registry	0.3	0.2	0.2	0.2	0.2
Total	**$234.7**	**$141.6**	**$114.7**	**$115.3**	**$115.9**

[1] Expanded Medicaid benefit to include residential treatment; funding mandate is $50.0 million over five years.
[2] Funding includes $24.0 million for hospital subsidies and $35.0 million for physician subsidies.

Additional Comments: To the extent the bill reduces the number of uninsured Marylanders, uncompensated care expenses will decrease.

Exhibit 4 displays 2009 FPG by family size.

Exhibit 4
2009 Federal Poverty Guidelines

Family Size	200% FPG	300% FPG	400% FPG	500% FPG
1	$21,660	$32,490	$43,320	$54,150
2	29,140	43,710	58,280	72,850
3	36,620	54,930	73,240	91,550
4	44,100	66,150	88,200	110,250
5	51,580	77,370	103,160	128,950

Additional Information

Prior Introductions: None.

Cross File: HB 951 (Delegate Hubbard, *et al.*) - Health and Government Operations.

Information Source(s): Kent, Montgomery, and Worcester counties; Baltimore City; Department of Budget and Management; Department of Human Resources; Department of Health and Mental Hygiene; Maryland Insurance Administration; Comptroller's Office; Department of Labor, Licensing, and Regulation; Department of Legislative Services

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