Department of Legislative Services

Maryland General Assembly
2009 Session

FISCAL AND POLICY NOTE

Senate Bill 515 (Senator Middleton)
Finance and Budget and Taxation

Healthy Maryland Program

This bill modifies the Maryland Health Insurance Plan (MHIP) to be the Healthy Maryland Program. Beginning January 1, 2010, every resident without access to employer-sponsored health care coverage must enroll in the program. Employers with nine or more full-time employees that do not offer and contribute to a group health plan must pay a per-employee contribution. Individuals with incomes over 300% of federal poverty guidelines (FPG) that do not maintain continuous health care coverage are subject to a tax penalty. Per-employee and tax penalty revenues are used to subsidize lower-income individuals in the program.

The bill takes effect July 1, 2009, with the exception of the tax penalty provisions, which take effect January 1, 2010, and apply beginning with tax year 2010.

Fiscal Summary

State Effect: Special fund revenues increase by a significant amount in FY 2010 from the mandated per-employee contribution and premium income. Special fund revenues further increase by $27.8 million in FY 2011 from tax penalties. General fund expenditures increase by $3.4 million in FY 2010 to administer the per-employee contribution. Special fund expenditures increase in FY 2010 to administer the Healthy Maryland Program, including collection of tax penalties. Only costs associated with enforcement and other activities required of the Comptroller's Office have been quantified. Significant other expenditures are required. Future years reflect annualization, inflation, and declining tax penalty revenues due to increased rates of insurance.

($ in millions)	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
SF Revenue	-	$27.8	$25.9	$18.1	$14.8
GF Expenditure	$3.4	$2.2	$2.3	$2.4	$2.5
SF Expenditure	-	$.2	$.1	$.1	$.1
Net Effect	($3.4)	$25.4	$23.5	$15.5	$12.2

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

Local Effect: None.

Small Business Effect: Meaningful. Small businesses with nine or more full-time employees may be subject to the per-employee contribution or penalties from the Commissioner of Labor and Industry.

Analysis

Bill Summary:

Healthy Maryland Program: Beginning July 1, 2009, the program must enroll any eligible residents without access to employer-sponsored health care coverage. The program will be overseen by the Healthy Maryland Program Board (the former MHIP board). All underwriting risk must be borne by participating carriers. The program will provide subsidies to residents without access to employer-sponsored health care coverage and incomes below certain levels as established by the board. Enrollment of individuals entitled to a subsidy must be capped based on available funding.

Coverage Requirements: Coverage must (1) be issued on a guaranteed-issue basis; (2) include benefits approved by the board; and (3) have no preexisting condition limitations or medical underwriting. The board must establish a standard benefit package that is affordable and comprehensive; thus, coverage may exclude mandated benefits, coverage, and reimbursement requirements otherwise imposed on health benefit plans. The benefit package must include incentives for healthy behavior and provide first-dollar coverage for preventive services. A change in the standard benefit package is not effective until six months after adoption by the board.

Rating: The board must establish a community rate for program coverage. The community rate may be adjusted only for age, family composition, and incentives for healthy behavior. Rates may not be adjusted for health status or occupation. The board may allow a rate that is 40% above or 50% below the community rate. Carriers must be allowed a reasonable administrative fee and a margin of 2% to be included in rates. Each participating carrier must charge the standard premium rates. Each carrier, by March 31 of each year, must report to the board its actual medical and administrative costs for the previous year and any request for rate adjustment.

Carrier Requirements: Carriers that participate in the small group market must participate in the program; otherwise, participation is voluntary. A carrier that ceases to participate in the program may not reenter the program or participate in the small group market for five years. A carrier may remain in the small group market without participating in the program if the carrier experiences cumulative losses under the program exceeding $50.0 million or 10% of premiums or greater in two consecutive years.

Each carrier must develop a master plan document that includes benefits, exclusions, preauthorization and utilization review guidelines, any limitations on provider selection, cost-sharing requirements, and procedures for presenting claims. Each master plan must be approved by the board. Each carrier must also develop a certificate of coverage that must be updated as necessary and provided to program enrollees at specified times.

Mandated Per-employee Contribution: Employers with nine or more full-time employees that do not offer a group health plan to which the employer makes a fair and reasonable premium contribution must pay a per-employee contribution. The Maryland Health Care Commission (MHCC) will determine the required contribution annually based on the average premium contribution made by employers in the small group market. The Commissioner of Labor and Industry must determine and collect the contribution and assess a penalty on an employer that fails to make the contribution. The commissioner must distribute the per-employee contributions and penalty revenues to the Healthy Maryland Program Fund.

Tax Penalties: Individuals who do not maintain continuous health care coverage for themselves and any dependent child during the taxable year are subject to a penalty of $1,000. For a married couple filing a joint return, the penalty is $2,000, unless each spouse and each dependent child of the married couple had continuous health care coverage. If only one spouse in a married couple and each dependent child had continuous coverage, the couple is subject to a $1,000 penalty. The penalty is applicable to tax year 2010 and beyond.

The penalties do not apply to a nonresident, including a nonresident spouse or a nonresident dependent. The Comptroller must provide an exception for an individual (1) whose annual premium costs would exceed 6% of federal adjusted gross income; (2) whose annual income is below 300% FPG or (3) who objects to health insurance on religious grounds. The Comptroller must distribute penalty revenues to the Healthy Maryland Program Fund, after deducting a reasonable amount for administrative costs.

Taxpayers have to indicate on their income tax return whether they have the required coverage.

The Comptroller has to publicize the health care coverage requirement to provide adequate opportunity for individuals to obtain coverage and avoid a penalty.

Healthy Maryland Fund: The bill renames the MHIP Fund the Healthy Maryland Fund and alters the revenue sources to the fund by repealing premiums for MHIP coverage (defunct under the bill) and adding revenues from the per-employee contributions and tax penalties required under the bill.

Current Law/Background:

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 (standard plan) that carriers must sell to small businesses (2 to 50 employees). Carriers must offer the standard plan to all small businesses, but may sell additional benefits or enhancements through riders. Any riders must be offered and priced separately. 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 (currently 10%).

Carriers must use a community rate that must be 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.

According to MHCC, there are 53,671 employers and 427,738 employees participating in CSHBP. Only eight carriers participated in 2007, with the top two insurers having a combined market share of about 86% of the small group market. The average premium in 2007 for an HMO plan with riders (the most common plan purchased) was $4,560 for employee-only coverage and $12,204 for family coverage.

While the small group market is not substantially impacted by the bill, several key aspects of the market such as guaranteed issue, no preexisting condition limitations, and some rating principles, are applied to coverage provided under the Healthy Maryland Program. Further, carriers that sell CSHBP must participate in the program.

Employer-based Health Care Coverage in Maryland: According to MHCC, in 2006-2007, 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). Access to employer-based insurance has declined from 78% in 2000-2001.

Uninsured in Maryland: According to MHCC, in 2006-2007, 15.4% of Maryland's noneldery population was uninsured, 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. Those working in smaller private firms (fewer than 100 employees) are disproportionately represented among uninsured workers (62% compared with 37% of all workers).

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. The plan began taking applications on July 1, 2008, and as of September 24, 2008, had enrolled approximately 1,000 individuals. Florida allows low-cost insurance, 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.

Pennsylvania covers children from families with incomes up to 300% FPG through its Children's Health Insurance Program and allows families with incomes above 300% FPG to buy into the program at full cost. New Jersey recently enacted a law that requires all children to have health insurance by July 2009. New Jersey's Children's Health Insurance Program covers children up to 350% FPG and allows parents with incomes above 350% FPG to buy into its program at a cost of $137 per month for one child, $274 per month for two children, and $411 per month for three or more children.

ERISA: The federal Employee Retirement and Income Security Act (ERISA) of 1974 contains a preemption clause stating that the Act "shall supersede any and all State laws insofar as they relate to any employee benefit plan." These benefits include health care. State reforms have often come into conflict with ERISA when they relate, directly or indirectly, to employee benefits. States cannot mandate that employers pay for health insurance, directly tax benefit plans, or require reports on cost or use of the plans from employers.

States are permitted to "regulate the business of insurance." Through this clause, states have tried to side-step ERISA, usually without success. For instance, the U.S. Court of Appeals for the Fourth Circuit in 2007 upheld the decision of the lower court in ruling that the Maryland "Fair Share Health Care Act," which mandated employee health care coverage by certain large employers is preempted by ERISA. However, in 2008, the Ninth Circuit upheld a San Francisco ordinance that requires certain employers to pay for

health insurance or health care expenses for their employees or pay into a fund, ruling that this requirement was not prompted by ERISA.

State Revenues:

Tax Penalties: Special fund revenues to the Healthy Maryland Program Fund increase by $27.8 million in fiscal 2011 from tax penalties imposed on individuals and married couples with adjusted gross incomes of 300% FPG or higher that do not maintain the required coverage. This estimate is based on the following facts and assumptions:

- approximately 227,000 individual and joint filers with incomes 300% FPG or more will not have health insurance in tax year 2010;
- 136,200 (60%) will indicate that they have obtained health insurance to avoid the surcharge;
- 90,800 will be subject to the surcharge;
- 50% of the individuals subject to the surcharge (45,400) will meet one of the bill's exceptions;
- 31,780 will be assessed surcharges (70% compliance rate);
- 90% of the amount assessed will be collected; and
- 75% of the amount assessed will be collected within the same fiscal year.

Legislative Services notes that this estimate is considerably higher than actual revenues achieved in Massachusetts. For tax year 2007, about 95% of Massachusetts tax filers indicated that they had health insurance coverage. Of the 5% (168,000) of filers who were uninsured, 69,000 (40%) were exempt from penalties. As of November 2008, Massachusetts collected only $4.3 million in tax penalties for tax year 2008. Maryland's uninsured rate (15.4%) is substantially higher than the uninsured rate in Massachusetts (an estimated 7.0% in 2007).

Mandated Per-employee Contribution: Special fund revenues to the Healthy Maryland Program Fund further increase beginning in fiscal 2010 due to collection of a per-employee contribution from certain employers and penalties assessed on employers who fail to make the required contribution. The amount of revenues cannot be reliably estimated at this time and will depend on (1) the extent to which employers with nine or more full-time employees do not offer group health plans to which they make fair and reasonable premium contributions; (2) the number of employees associated with these employers; (3) the amount of the required per-employee contribution (to be set annually by MHCC); and (4) compliance with the requirement on the part of employers. Whereas the tax penalties under the bill are specified, the per-employee contribution amount and any penalties for noncompliance with the contribution are not specified.

According to the 2006 Medical Expenditure Panel Survey, there are 49,761 private-sector establishments in Maryland with 10 or more employees. Together, these establishments have 1,390,651 full-time employees. In 2006, 43,774 (88%) of these establishments offered health insurance, while 5,987 (12%) did not. For those establishments that offered insurance, it is unknown whether the employer's premium contribution was "fair and reasonable."

For illustrative purposes only, Massachusetts requires employers with 11 or more workers to make a "fair and reasonable contribution to coverage" or pay a $295 annual assessment per worker. To date, about 650 firms have been assessed for about $7.0 million. In September 2008, Massachusetts' Division of Health Care Financing tightened regulations to increase the number of employers subject to the assessment in hopes of generating an estimated $30.0 million in additional revenues from the assessment.

Healthy Maryland Program: Special fund revenues increase by a significant amount beginning in fiscal 2010 from premiums paid by Healthy Maryland Program enrollees. This amount cannot be reliably estimated at this time and will depend on the number of enrollees, the premiums established for the program, and the subsidy schedule for low-income enrollees.

State Expenditures:

Mandated Per-employee Contribution: General fund expenditures for the Department of Labor, Licensing, and Regulation (DLLR) increase by $3.4 million in fiscal 2010, which accounts for the bill's October 1, 2009 effective date. This estimate reflects the cost of hiring 26 full-time positions and associated start-up costs to develop and maintain an employer database on an estimated 164,556 employers, collect employer information, process reports, assess and collect contributions, establish and manage a collection system, and impose penalties on noncompliant employers. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses. The bill does not provide for administrative expenses to be covered by per-employee contribution revenues. Therefore, general funds are required for these expenses.

Positions	26
Salaries and Fringe Benefits	$1,093,555
One-time Start-up Costs	1,750,000
Ongoing Contractual Services	243,750
Other Operating Expenses	303,763
Total FY 2010 State Expenditures	**$3,391,068**

Future year expenditures reflect full salaries with 4.4% annual increases, 3% employee turnover, and 1% annual increases in ongoing operating expenses.

Tax Penalties: General fund expenditures for the Comptroller's Office increase by $250,000 in fiscal 2010 to publicize the bill's requirements in advance of the tax penalty, which begins in tax year 2010. Publicity must provide adequate opportunity for individuals to obtain health care coverage and avoid a tax penalty.

Special fund expenditures for the Comptroller's Office increase by $172,108 in fiscal 2011, which accounts for the January 1, 2010 effective date of the bill's tax provisions. This estimate reflects the cost of hiring two revenue examiners to audit returns and a one-time only expense to alter tax year 2010 income tax forms to collect the information necessary to calculate and assess the required penalty. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses. Unlike with the administrative costs for the per-employee contribution, the bill does allow the Comptroller to deduct a reasonable amount for administrative costs to collect tax penalties. Therefore, special funds are used for these expenses.

Positions	2
Salaries and Fringe Benefits	$52,254
One-time-only Tax Form Alterations	111,360
Other Operating Expenses	8,494
Total FY 2011 State Expenditures	**$172,108**

Future year expenditures reflect full salaries with 4.4% annual increases, 3% employee turnover, and 1% annual increases in ongoing operating expenses.

Healthy Maryland Program: Special fund expenditures increase by a significant amount beginning in fiscal 2010 to administer the Healthy Maryland Program. This amount cannot be reliably estimated at this time and will depend on the number of enrollees, the

number of subsidized enrollees, claims experience, and administrative expenses. Legislative Services assumes that these costs will be paid from the Healthy Maryland Fund using revenues from the current MHIP assessment ($114.9 million in fiscal 2010), enrollee premiums, the per-employee contribution, and tax penalties. Expenditures will be further offset by hospital uncompensated care savings achieved from currently uninsured individuals enrolling in the program.

For illustrative purposes only, CareFirst BlueCross BlueShield prepared an actuarial analysis of the cost to implement a proposal similar to the bill. This analysis estimates a total cost per member per month of $253. A total of 537,867 individuals were estimated to enroll in the program for a total cost of $1.6 billion. These costs would be offset by revenues from the current MHIP assessment, premiums, the per-employee contribution, and tax penalties, as well as anticipated savings from averted hospital uncompensated care.

Small Business Effect: To the extent that small businesses with between 9 and 50 employees do not offer a group health plan to which they make a fair and reasonable premium contribution, they will be subject to a per-employee contribution. Small businesses subject to this contribution that do not comply may also incur unspecified penalties from the Commissioner of Labor and Industry. According to the 2006 Medical Expenditure Panel Survey, there are 21,540 establishments with 10 to 49 full-time employees in Maryland. An estimated 20% of these establishments (4,308) do not offer health insurance. It is unknown whether those establishments that do offer health insurance will be found to provide a "fair and reasonable" contribution under the bill. The amount of the per-employee contribution and any potential penalty for noncompliance is not specified in the bill.

Additional Comments: **Exhibit 1** displays the 2009 federal poverty guidelines by family size for 300% FPG.

Exhibit 1
2009 Federal Poverty Guidelines

Family Size	300% FPG
1	$32,490
2	43,710
3	54,930
4	66,150
5	77,370

Additional Information

Prior Introductions: None.

Cross File: HB 860 (Delegate Hammen) - Health and Government Operations.

Information Source(s): *2006 Medical Expenditure Panel*, Agency for Healthcare Research and Quality; *Health Insurance Coverage in Maryland Through* 2007, Maryland Health Care Commission, January 2009; Community Catalyst; Maryland Health Insurance Plan; 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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Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510