

# Maryland Policy *Reports*

Analysis from the Maryland Budget and Tax Policy Institute

## Maryland Children's Health Program Has Stalled

More Are Uninsured; Budget 'Savings' Increase  
Statewide Health Costs

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### Summary

- **MCHP Has Stalled:** The Maryland Children's Health Program (MCHP), which has been one of the nation's leaders in providing coverage to uninsured children, has stalled. MCHP enrollment is flat and, for the first time in years, the number of uninsured Marylanders appears to be rising.
- **MCHP Spending May Be Cut:** State policy makers are examining ways to trim state spending to balance the budget. The General Assembly cut MCHP spending during the 2003 legislative session and may cut it further.
- **MCHP Cuts Harm Children:** Studies show that children without health insurance receive less care, including immunizations, dental care, prescription drugs, and other health-related services. These children may be less healthy and more likely to suffer developmental delays that hinder educational attainment.
- **MCHP Cuts Cost Money:** MCHP transfers much of the cost of covering uninsured children to the federal government, which pays 65 percent of program costs. Cutting MCHP will transfer this financial burden back to Marylanders. State budgetary savings will be minimal, as MCHP cuts are largely offset by increased spending on other state health programs. Meanwhile, higher levels of uncompensated care will drive up private health care costs by millions of dollars per year.

## **MCHP: Bipartisan Support and Rapid Early Growth**

The Maryland Children's Health Program (MCHP) is a joint federal-state program that provides health insurance to low income children, primarily those below 200 percent of the Federal Poverty Level (\$30,520 for a family of three in 2003). Subsidized insurance is provided for children in families up to 300 percent of the Federal Poverty Level (FPL). The federal program was signed into law by President Clinton on August 5, 1997. The Maryland program was launched on July 1, 1998.

The federal law, known as the State Children's Health Insurance Program (SCHIP), was enacted to address what was, at that time, a growing national population of uninsured children. The initial law authorized a \$40 billion block grant to states for child health insurance programs over a ten year period (federal fiscal years 1998-2007). The bill received bipartisan support in both the House and the Senate.<sup>1</sup>

Since then, the law has contributed to a reversal in the number of children without health insurance. Nationally, the number of uninsured children declined from 9.9 million (13.9 percent) in 1997 to 7.8 million (10.8 percent) in 2001,<sup>2</sup> while the number of children enrolled in the SCHIP program rose from 0 to 3.4 million in December 2001, and to 3.7 million in December 2002.<sup>3</sup>

Legislation authorizing the Maryland program (SB 85) was enacted during the 1998 legislative session. MCHP (pronounced em-chip) was partially integrated into the state's Medicaid program, launched on July 1, and quickly became one of the nation's leading programs. Spending and program enrollment both grew rapidly in the early years, surpassing the expectations of even its own administrators. By the end of FY 2001, there were almost 89,000 children enrolled, nearly 50 percent more than the 60,000 that were originally projected for that date.<sup>4</sup> Several million dollars in additional federal grant money were reallocated to Maryland

from other states that did not grow as quickly. By FY 2003 the state was spending an estimated \$208 million on the program, of which about \$135 million was federal funds and \$73 million was state funds (about 0.7 percent of state general revenue spending).<sup>5</sup> An estimated 113,600 children were enrolled statewide.<sup>6</sup>

Due to this aggressive early growth, Maryland has enrolled a significantly higher share of its low-income children than the national average. According to the latest Census Bureau data, Maryland's share of children living in poverty is 0.9 percent of the national total.<sup>7</sup> Its share of children below 200 percent of the poverty threshold who are uninsured is about 1.1 percent of the national total.<sup>8</sup> By contrast, as of December, 2002, the latest period for which there is state-by-state data, Maryland's share of all enrollees in SCHIP nationally was 2.96 percent, a much higher percentage than might be expected given the state's level of poverty and number of uninsured children.<sup>9</sup>

While there is insufficient data to know with certainty, Maryland's efforts have probably significantly reduced the number of uninsured children statewide. Recent Census Bureau estimates indicates that there was an average of 49,000-79,000 Maryland children under 19 who were poor (living at or below 200 percent of the FPL) and lacked health insurance during any given year from 1999-2001.<sup>10</sup> However, this number would probably have been higher without MCHP, given that SCHIP has contributed to a decline in the number of uninsured poor children nationally and that Maryland has had one of the nation's leading programs.

## **MCHP Premium**

MCHP originally only provided coverage to children in families below 200 percent of the Federal Poverty Level. During the 2000 legislative session, the General Assembly enacted legislation

(SB 863/HB 2) that provided subsidized health coverage to children up to 300 percent of the Federal Poverty Level. The amended program was approved by the federal Centers for Medicare and Medicaid Services (CMS) on November 7, 2000. The program was launched on July 1, 2001, following a Department of Health and Mental Hygiene outreach campaign that included radio and cable television public service announcements in both English and Spanish.<sup>11</sup>

Despite these efforts, enrollment in MCHP Premium, as the program is called, has so far been modest. Unlike MCHP, enrollees in MCHP Premium are required to pay a monthly family contribution of \$40 or \$50 per month, depending on their income. Only 4,344 children were enrolled in the program by December, 2002, far below the 14,700 that had been projected by that time. A Department of Legislative Services analysis suggested that outreach efforts may have been ineffective and that family premiums and complicated enrollment requirements may have dissuaded many others.<sup>12</sup> A smaller, employer-sponsored insurance program, which had also been created by the 2000 law, had only 159 children

enrolled in FY 2003, and is now being phased out.<sup>13</sup>

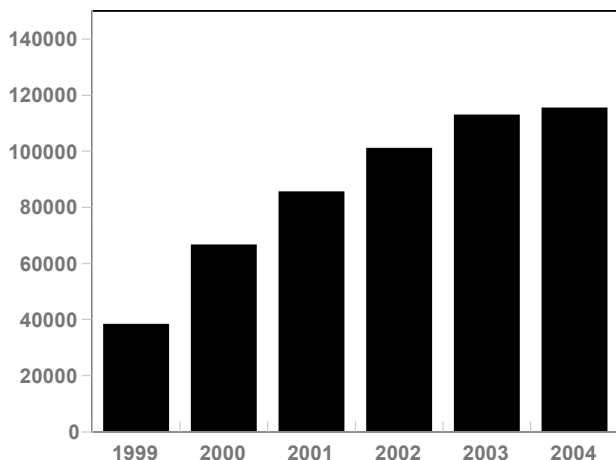
### Program Stalls as Budget Deficits Loom

Governor Robert Ehrlich came to office during a period of declining state revenues and increased budget deficits. His first budget, submitted to the General Assembly in January, 2003, essentially flat funded the MCHP program, providing only a small increase that partially offset increased costs due to inflation. The General Assembly cut the governor's proposed spending level by \$3.8 million.

The changes became law on July 1 of this year. As required by law, the Department of Health and Mental Hygiene has since implemented the cuts by:

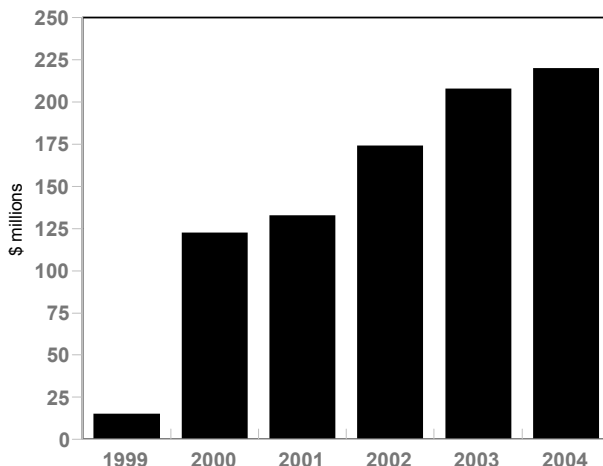
- freezing new enrollees in the MCHP program who are in the 200-300 percent of Federal Poverty Level income group (\$30,520-45,780 for a family of three);

**MCHP and MCHP Premium Enrollment  
FY 1999-2004**



Source: Maryland Department of Legislative Services, October, 2003. MCHP Premium became effective in FY 2002.

**MCHP and MCHP Premium Spending  
Total State and Federal Spending, FY 1999-2004**



Source: Maryland Department of Health and Mental Hygiene for FY 1999-2003. FY 2004 is Maryland Budget and Tax Policy Institute estimate based on Maryland Department of Legislative Services data.

- imposing new premiums of \$37 per month on enrollees in the 185-200 percent FPL income group (\$28,231-30,520 for a family of three) and reclassifying this group as MCHP Premium, an action that the Department of Health and Mental Hygiene projects could lead to a loss of 3,000 program enrollees; and
- eliminating the employer sponsored enrollment option that had been created as part of the 2000 legislative expansion, moving these enrollees to managed care.<sup>14</sup>

These changes mark a turning point for a program that, until this year, had experienced steady growth as part of an aggressive effort to reduce the number of uninsured children statewide. While overall spending on the program is expected to continue to grow, this will be primarily due to continued health care inflation, not significant changes in enrollment. After the imposition of the new premiums and enrollment freeze, the Department of Legislative Services projects that enrollment growth will slow to about 2 percent in FY 2004, with enrollment rising from 113,201 to 115,587.<sup>15</sup> Even this projection assumes that the

General Assembly will provide further funding to cover projected shortfalls for the current fiscal year.<sup>16</sup> After years of aggressive growth, the MCHP program has stalled.

This halt, even if temporary, comes at a difficult time. According to the Census Bureau, from 1999-2001 about 15-25 percent of Maryland children under 200 percent of the FPL remained uninsured (about 49,000-79,000 children).<sup>17</sup> The latest Census estimate for 2002 indicates a rising percentage of uninsured Marylanders for the first time in years. Such increases tend to be concentrated among the state's poor. Along with rising unemployment and poverty, the number of uninsured children in Maryland may now be growing for the first time in years.<sup>18</sup>

### **MCHP's Benefits and Cost Savings**

When states are experiencing budget deficits, as Maryland is today, it is not uncommon for taxes to be raised and spending cuts to be made in many, often popular, programs. In the case of MCHP, however, these cuts may be counterproductive. MCHP cuts could leave thousands of Maryland children uninsured, save the state budget little money and, through increased uncompensated care, increase private sector health care costs by millions of dollars per year.

The adverse effects of such cuts on children are well documented. Children with health insurance see doctors more frequently and are more likely to receive needed care.<sup>19</sup> One study found that insured children were more likely to receive well-child care, dental care, immunizations, and other specialty-related care.<sup>20</sup> Another found that they have greater access to prescription drugs.<sup>21</sup> An evaluation of California's SCHIP program found that children in poor health who were enrolled in the program experienced significant health improvements after only one year.<sup>22</sup> Overall, uninsured children are more likely to suffer developmental delays that affect educational

#### **MCHP Benefits**

- Doctor visits (well and sick care)
- Immunizations (shots)
- Hospital care
- Prescription medicines
- Lab work and tests
- Transportation to medical appointments
- Dental care
- Mental health services
- Vision care
- Substance abuse treatment

Source: Maryland Department of Health and Mental Hygiene. Available online at <http://www.dhmdh.state.md.us/ma/mchp/>

achievement and life prospects.<sup>23</sup> These results are consistent with MCHP's benefits package (see box).

Cutting MCHP would save the state government little money, and cost the state as a whole several million dollars per year, once all public and private health care spending is considered. The reason is simple: MCHP transfers nearly two-thirds (65 percent) of the cost of covering uninsured children to the federal government. While insured children generally receive more care than those who are uninsured, and at greater cost (about 50 percent more, on average),<sup>24</sup> the federal subsidy makes it possible to provide this care at lower net cost to the state. Cutting MCHP merely redirects federal dollars to other states, and Marylanders are left with higher health care bills.

The biggest loser, financially, would be Maryland residents, businesses, and health care organizations, which together shoulder most of the burden of uncompensated care. According to a study by the Department of Health and Mental Hygiene, the total cost of uninsured care in Maryland ranges from \$1.4 - 1.7 billion per year. This estimate includes \$300-500 million in uncompensated hospital care and another \$363 million in uncompensated care provided by physicians. Roughly \$410-450 million is absorbed by state and local health programs and schools. The uninsured pay for about 20 percent of the total cost of their care, but much of this is offset by higher costs, as opportunities for inexpensive preventive care are missed and more care is provided in expensive hospital settings.<sup>25</sup>

The impact of MCHP cuts on the state budget are less clear. While such cuts would probably generate a net savings, this would be at least partially offset by increased spending on other state programs. For example, Medicaid costs would increase, driven by higher hospital billings as hospitals recoup the cost of additional uncompensated care through the state's all-payor system. Spending on state mental health and substance abuse programs would also

rise, as would spending by local health departments, which receive significant state-provided assistance on a formula basis.<sup>26</sup>

Moreover, studies have shown that federal health care grants like MCHP stimulate state economies, while cuts have the opposite effect.<sup>27</sup> While federal subsidies lower the cost of coverage to Marylanders, more care is provided and more money is spent overall. Federal S-CHIP grants currently bring in over \$140 million per year from outside the state, creating thousands of jobs both in the health care industry and in other areas of the state economy, as health care workers spend their wages on other goods and services. Cutting MCHP, therefore, contributes to job loss. This generates a modest loss in state tax revenues, further reducing the initial savings generated by cutting the program.

Given rising national deficits and the block grant nature of SCHIP, federal matching funds for MCHP may not be available indefinitely. However, as recently as August, Congress extended the availability of \$2.7 billion in SCHIP funds that had been scheduled to expire unspent.<sup>28</sup> For now, even during tight budgetary times, the costs of cutting MCHP outweigh the modest savings that would be generated. Spending reductions increase the ranks of the insured, worsen child health, and eliminate jobs both in and outside the health care system while providing little state budgetary savings.

## **The Impact of MCHP Spending Cuts**

Policy makers are considering several options for cutting MCHP spending, each of which is discussed in more detail in this section.

***Restrict Eligibility:*** One option for containing MCHP spending is to restrict new enrollments. The current state freeze on new enrollees who are between 200-300 percent of the Federal Poverty Level could be extended beyond June 30, 2004, the end of the current state fiscal year. It could be

## How Affordable are Premiums?

For many current and former enrollees in the MCHP program, premiums were a significant barrier to enrollment, no matter how reasonably priced. The following quotes are from focus groups of MCHP parents conducted by the Department of Health and Mental Hygiene.

“I keep saying I’m going to get it [health coverage] for my family, but it always gets pushed to the bottom because you have all these other expenses that you have to take care of...your rent, your car, whatever else, just to live and survive. I keep praying that neither of my kids get really sick because an emergency will wipe me out...so I know it’s something that I have to do, but like I said, it keeps getting pushed to the back burner because of economics.”

“My daughter was covered through the State [MCHP Premium] but when it came time to send in the next premium, we needed the money for something else. I just found out a few weeks ago my husband has needed the money to pay other bills. I guess we’re just really behind on a lot of stuff, and he’s been using the money we were sending to the State to pay off some other things.”

“If I was making \$50,000 a year then \$40 a month wouldn’t be a problem. It would be just another utility bill, phone bill or something like that...but pretty much all of my expenses right now are something that I have to pay. I can’t get around those [expenses]. Health coverage I can because my kids just aren’t that sick.”

Source: Maryland Department of Health and Mental Hygiene. Results of the 2002 Maryland Children’s Health Program (MCHP) Premium Focus Group Project. Draft Report, October, 2003.

extended to the 185-200 percent group and even to those below 185 percent if the state elects to move this group outside of the Medicaid program.

Continuing and expanding the freeze would erode total enrollments over time, as current enrollees drop out. According to the Department of Legislative Services, however, the current freeze on those in the 200-300 percent group only affects about 6 percent of all current MCHP enrollees, so this policy is more likely to hinder future spending increases than to reduce current spending.

**Maintain/Extend Premiums:** Under federal law, states may impose cost-sharing arrangements, including premiums and copayments, on SCHIP enrollees who are not enrolled in the Medicaid

program.<sup>29</sup> In general, such cost-sharing generates little revenue, particularly after administrative costs are accounted for. The primary savings created are due to reduced enrollments.

Maryland now imposes premiums on all MCHP enrollees at or above the 185 percent threshold. Enrollees in the 185-200 percent group pay a \$37 per month premium under new regulations issued this year. The Department of Health and Mental Hygiene estimates that the premium will reduce enrollments in this group by about half.<sup>30</sup> MCHP Premium enrollees in the 200-300 percent group pay a \$40 or \$50 per month premium per family, depending on their income level. Premiums are cited as a reason why MCHP Premium has not expanded as quickly as the main MCHP program.

Federal law limits total cost sharing to no more than 5 percent of a family's income. Maryland's current premium is a bit less than 2 percent of family income in most instances.

DHMH recently assembled several focus groups of parents of current and former MCHP enrollees. When asked, most indicated that they did not think that current MCHP premiums were unreasonably costly, particularly when they were aware of MCHP's benefits. Nevertheless, many found that their family budgets were so tight that they had difficulty paying even a small premium, particularly when their children seemed healthy and they believed that their current economic circumstances were likely to change soon (see box).

**Implement Copayments or Deductibles:** Like premiums, copayments and deductibles are a way to save money by shifting some of the cost to enrollees and their families. Copayments differ from family premiums in several ways, however. Premiums, which are paid monthly, are more regular and predictable than copayments, which are paid at the time an enrollee receives services, or shortly thereafter. Several participants in the DHMH focus groups expressed a preference for the predictability of premiums.

Unlike premiums, however, which involve a constant upfront charge regardless of the health of the child, copayments and deductibles are tied to program usage. This direct tie may reduce disincentives for parents to enroll their children if they believe they are healthy and that non-urgent care can be delayed. On the other hand, copayments and deductibles may reduce the amount of care given to children once they are enrolled, and impose disproportionate costs on enrollees who need more care.

Maryland's usage of copayments and deductibles in the MCHP program is relatively minor at present. The Department has recently issued proposed regulations that would institute a \$1 copayment for transportation services. Copayments could be more

widely applied if further cuts are adopted by the General Assembly.

Because they require payments by the families of enrollees, premiums, copayments and deductibles are likely to reduce overall program usage, and because the payments involved are small, little revenue is likely to be generated. Most savings generated are due to fewer children being enrolled and less care being utilized.<sup>31</sup>

**Trim Benefits:** Secretary of Health and Mental Hygiene Nelson Sabatini recently described the MCHP benefits package as "rich" compared those in private health care plans.<sup>32</sup> The Department has not released any analysis or other documents indicating which benefits are superfluous, however. In fact, state health analysts appear to believe that very little, if any, savings could be achieved by cutting the current benefit package.

## Conclusion

MCHP's immediate future will be determined next January in either the governor's budget submission, an administration-backed comprehensive health care plan, or both. While MCHP's future is unclear, its current status is not. Enrollment growth has slowed to a trickle and, absent an infusion of new funding (unlikely in the current budgetary environment), enrollment could actually decline in the coming years. Even now, with unemployment and poverty rising statewide, the number of uninsured in the state appears to be rising again for the first time in years.

Due to the heavily subsidized nature of the program, with the federal government covering most program costs, further cuts in MCHP like those imposed by the General Assembly during the 2003 session would be unwise. Such cuts produce only minor savings in the state budget while increasing health care costs for the state as a whole, once both public and private health care costs are considered.

## End Notes

- <sup>1</sup> SCHIP was included in the Balanced Budget Act of 1997 (PL 105-33) and can be found in Title XXI of the Social Security Act. The BBA passed the House 346-85 and the Senate 85-15. All Maryland House and Senate members voted for the bills.
- <sup>2</sup> Mathematica Policy Research and the Urban Institute, "Interim Evaluation Report: Evaluation of the State Children's Health Insurance Program," February 26, 2003. Available online at <http://aspe.hhs.gov/health/schip/interimrpt/index.htm>
- <sup>3</sup> Kaiser Commission on Medicaid and the Uninsured, "SCHIP Program Enrollment: December 2002 Update," Vernon K. Smith and David M. Rousseau, July 2003.
- <sup>4</sup> Maryland SCHIP annual report for federal fiscal year 2001, p. 17. Available online at <http://cms.hhs.gov/schip/chipmd.asp>
- <sup>5</sup> Maryland Department of Health and Mental Hygiene. Financial estimates include all MCHP spending, most of which is in the state Medicaid budget, but a smaller portion of which is managed by the state Mental Hygiene Administration.
- <sup>6</sup> Maryland Department of Legislative Services. Notably, in August 2003 the Department of Health and Mental Hygiene reclassified about 6,000 MCHP enrollees as Medicaid enrollees. This will result in a lower estimate of MCHP enrollees when annual numbers are reissued in the coming months. This decline will not reflect a cut in the number of children who are insured, however, just a shift in classification from one state program to another.
- <sup>7</sup> U.S. Census Bureau, 2001 poverty data. The national poverty rate for children under 18 in 2001 was 16.3 percent. The poverty rate for children under 18 in Maryland in 2001 was 7.6 percent. Data is available online at [http://ferret.bls.census.gov/macro/032002/pov/new25\\_003.htm](http://ferret.bls.census.gov/macro/032002/pov/new25_003.htm).
- <sup>8</sup> U.S. Census Bureau, "Low Income Uninsured Children By State: 1999, 2000, and 2001," October 22, 2002. Available online at <http://www.census.gov/hhes/hlthins/liuc01.html>
- <sup>9</sup> Vernon K. Smith and David M. Rousseau, "SCHIP Program Enrollment: December 2002 Update," Kaiser Commission on Medicaid and the Uninsured, July 2003. Data is from Table 1, p. 2.
- <sup>10</sup> U.S. Census Bureau, *supra* note 8. The expressed range represents plus or minus one standard deviation.
- <sup>11</sup> Vernon K. Smith and David M. Rousseau, "SCHIP Program Enrollment: December 2002 Update," Kaiser Commission on Medicaid and the Uninsured, July 2003, p. 6.
- <sup>12</sup> Maryland Department of Legislative Services, "Operating Budget Analysis: Medical Care Programs Administration," Spring 2003, p. 44.
- <sup>13</sup> *Ibid.*
- <sup>14</sup> On July 9, the Department submitted these cuts for review to the General Assembly's Joint Committee on Administrative, Executive, and Legislative Review (AELR), where they were rejected by a vote of 11-5. A departmental assistant attorney general later issued an opinion that concluded that the cuts were required by law and the department proceeded with the cuts as drafted. These changes were projected to save approximately \$2.2-2.4 million in FY 2004.
- <sup>15</sup> According to the Department of Legislative Services, total MCHP and MCHP Premium enrollment for state fiscal years 1999-2004 are as follows: 38,395 in FY 1999; 66,797 in FY 2000; 85,668 in FY 2001; 101,272 in FY 2002; 113,201 in FY 2003; 115,587 in FY 2004. Totals include MCHP Premium from FY 2002 onward.
- <sup>16</sup> MCHP operates like an entitlement. State spending is driven by enrollment, rather than enrollment by spending. The Department of Legislative Services projects a \$10 million increase in spending for FY 2004 over what was previously appropriated based on an assumption that a deficiency appropriation will be enacted by the General Assembly in 2004 to cover additional costs due to inflation.

- <sup>17</sup> U.S. Census Bureau, *supra* note 8.
- <sup>18</sup> Nationally, the share of the population without health insurance rose from 14.6 percent to 15.2 percent in 2002. Data from Maryland shows a similar increase of about 0.7 percent (to 12.0 percent) over the previous two-year average (2000-2001) of 11.3 percent. The national number of uninsured also rose in 2001, but the Maryland numbers that year appeared to hold steady. Due to limited sample size, however, state-level data must be viewed with some caution. See US Census Bureau, "Health Insurance Coverage in the United States: 2002," September 30, 2003, p. 10. For 2001 data see US Census Bureau, "Health Insurance Coverage: 2001," p. 10.
- <sup>19</sup> Eugene M. Lewit, Ph.D., Courtney Bennett, Ph.D., and Richard E. Behrman, M.D. "Health Insurance for Children: Analysis and Recommendations," *The Future of Children*, Volume 13, No. 1 (Spring, 2003).
- <sup>20</sup> S. Eisert and P. Gabow, "Effect of child health insurance plan enrollment on the utilization of health care services by children using a public safety net system," *Pediatrics* (2002) 11(5): pp. 940-45.
- <sup>21</sup> E. Feinberg, K. Swartz, K., and A. Zaslavsky, et al. Family income and the impact of a children's health insurance program on reported need for health services and unmet health need. *Pediatrics* (2002) 109(2):e29.
- <sup>22</sup> Managed Risk Medical Insurance Board, "Health status assessment project—first year results," Sacramento, CA: 2002. Available online at [www.mrmib.ca.gov](http://www.mrmib.ca.gov).
- <sup>23</sup> Committee on the Consequences of Uninsurance, "Hidden Costs, Value Lost: Uninsurance in America," National Academies Press, 2003. Summary available online at <http://www.nap.edu/execsumm/030908931X.html>
- <sup>24</sup> The cost of care for insured children, who receive more and better care, is about 50 percent greater than for uninsured children. Because the federal government covers 65 percent of MCHP costs, the net effect is to reduce combined private and public costs at the state level by up to 50 percent for children who otherwise lack health insurance. Estimates on the cost of health care for insured and uninsured children are from Jack Hadley and John Holohan, "Covering the Uninsured: How Much Would It Cost?," *Health Affairs* (June 4, 2003).
- <sup>25</sup> Maryland State Planning Grant, "Calculating the Costs of Non-Insurance," June 5, 2003.
- <sup>26</sup> Maryland Department of Legislative Services.
- <sup>27</sup> Families USA, "Medicaid: Good Medicine for State Economies," January, 2003.
- <sup>28</sup> Families USA, "Congress Passes the SCHIP Fix," August 7, 2003.
- <sup>29</sup> In Maryland, children above 185 percent of FPL are outside Medicaid. Those below 185 percent are divided between Medicaid and MCHP depending on their age and income level. Those enrolled in Medicaid are: children aged 0-1 up to 185 percent of FPL; children 1-6 up to 133 percent; children 7 and older up to 100 percent. According to the Department of Legislative Services, as of August 30, 2003, out of a total enrollment of 107,379, the income distribution of MCHP enrollees was as follows: below 185 percent FPL = 94,801 (88.3%); 185-200 = 6,433 (6%); 200-250 = 4,790 (4.5%); 250-300 = 1,355 (1.3%).
- <sup>30</sup> See 30:15 Md. R. 1009 (July 25, 2003). Maryland Department of Health and Mental Hygiene estimate of economic impact included in proposed regulation on Maryland Children's Health Program (MCHP) Premium (10.09.43). Available online at [http://www.dsd.state.md.us/mdregister/3015/main\\_register.htm](http://www.dsd.state.md.us/mdregister/3015/main_register.htm)
- <sup>31</sup> Maryland Department of Health and Mental Hygiene. See also Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Premiums and Cost Sharing: The Impact of Low Income Populations," March, 2003.
- <sup>32</sup> Nelson Sabatini, "A Parental Responsibility," *Baltimore Sun*, August 21, 2003.

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## **About the Maryland Budget & Tax Policy Institute**

The Maryland Budget and Tax Policy Institute is a nonpartisan research organization that provides timely, accurate, and accessible analysis of state budget and tax issues. In addition to general budget and tax research and analysis, the Institute examines issues affecting vulnerable populations and the important community programs that serve them. For additional information on the Institute or to receive this newsletter on a regular basis, contact us at 301-565-0505 or visit our web site at [www.marylandpolicy.org](http://www.marylandpolicy.org). This report was written by Patrick Lester.

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